

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-00925  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS GUERCIO			2a. DATE OF DEATH MONTH DAY YEAR 01 11 79			2b. HOUR 358 M			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 06 95		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POSTAL CLERK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS GUERCIO			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLEMANTINE MAGGIO			13e. STREET ADDRESS 2538 W. LAFAYETTE AVENUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-2861		17. INFORMANT ADDRESS JOACHIM B. GUERCIO, 309 MONTROSE AVE. 21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular Disease</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29/79</u> , 19 <u>79</u> , to <u>1/11/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/11/80</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death.)									
22b. SIGNATURE <u>Dr. G. Premsky</u>			DEGREE M			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/11/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. PREMSKY			22e. ADDRESS MERCY HOSPITAL, BALTO MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 01-15-79		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MD.		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.			24b. ADDRESS 21229			25a. DATE REC'D BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony Halbrudy</u>	

58-00852

1971 5/10/71



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR

2- DECEASED EVER IN U.S. ARMED FORCES?

3- SEX

4- RACE

5- DATE OF BIRTH

6- AGE (IN YEARS LAST BIRTHDAY)

7a- BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b- CITIZEN OF WHAT COUNTRY?

8- MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9- BALTIMORE CITY OR COUNTY OF DEATH

10- CITY OR TOWN OF DEATH

11- NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b- KIND OF BUSINESS OR INDUSTRY

13a- USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b- COUNTY

13c- BALTIMORE CITY OR COUNTY

13d- INSIDE CITY LIMITS? YES ☒ NO ☐

13e- STREET ADDRESS

14- FATHER'S NAME

15- MOTHER'S MAIDEN NAME

16a- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b- SOCIAL SECURITY NO.

17- INFORMATION

18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF

19a- DATE OF OPERATION

19b- CONDITION FOR WHICH OPERATION WAS PERFORMED

20a- AUTOPSY? YES ☐ NO ☐

20b- IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a- ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b- TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d- INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e- PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f- LOCATION STREET CITY OR TOWN COUNTY STATE

22a- I certify that (I) (this hospital) attended the deceased from 1-17-79, to 1-19-79, that (I) (we) last saw the deceased alive on 1-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b- SIGNATURE S. Pathmanathan

22c- DATE SIGNED 1-19-79

22d- PHYSICIAN'S NAME (TYPE OR PRINT) SINAKOLUNTHONATHAN PATHMANATHAN

22e- ADDRESS South Baltimore General Hospital Baltimore Maryland 21230

23a- BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation

23b- DATE Jan. 19, 1979

23c- NAME OF CEMETERY OR CREMATORY Security Process, Inc.

23d- LOCATION CITY OR TOWN COUNTY STATE Catonsville, Maryland

24- FUNERAL DIRECTOR NAME McCully Funeral Home of Brooklyn Balto., Md.

25a- DATE REC'D. BY REGISTRAR JAN 23 1979

25b- REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00926  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>OSCAR Hohing GUYNN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-19-79</b>			2b. HOUR <b>4:30 A.M.</b>				
3 SEX <b>male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 18 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		# UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b> Carpenter Home Const.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Baltimore</b>		13b. COUNTY <b>Baltimore</b>		13c. BALTIMORE CITY OR COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>703 Crosswell Road 21225</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANET SEXTON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>282-03-8450</b>		17. INFORMATION <b>Charlotte Scott 3225 Fredcrest Road 5825 3rd Ave. #204</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4092 <b>Cardiopulmonary Arrest</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									11 days.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) (b) (c) <b>Severe Atherosclerotic Peripheral Vascular Disease - Acute Renal Failure</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-17-79, to 1-19-79, that (I) (we) last saw the deceased alive on 1-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>S. Pathmanathan</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-19-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SINAKOLUNTHONATHAN PATHMANATHAN</b>						22e. ADDRESS <b>South Baltimore General Hospital Baltimore Maryland 21230</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Jan. 19, 1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home of Brooklyn Balto., Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP

TO THE SECRETARY OF THE INTERIOR  
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a specific area or project. Key words that are partially visible include "Bureau of Land Management", "Secretary of the Interior", and "Director of the Bureau of Land Management".]

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00927 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH F. HABEEB</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 27, 1979</b>			2b. HOUR <b>5:15P M</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 10 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hotel Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10405 46th Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Habeeb</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth UNK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219 14 6624</b>		17. INFORMANT ADDRESS <b>George Habeeb (Son) 10413 Deakins Hall</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										18b. BELTSLVILLE HOSPITAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Chronic renal insufficiency, Congestive Heart Failure</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 16</b> , 19 <b>79</b> , to <b>January 27</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 27</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Larry N. Stein</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/27/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Larry N. Stein, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b>				ADDRESS <b>11800 N.H. Ave. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert J. Cuddy</b>			

18-00051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00928 REG. NO.		
1- FOR STATE REGISTRAR							2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PEARL E. HACK</b>							1		10		79	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 18 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.						
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5106 Cordelia Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5106 Cordelia Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Spencer Hack</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary J. Cole</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-20-5694</b>		17. INFORMANT ADDRESS <b>Frieda Frazier 2047 Braddish Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intermittent Cardio Vascular</u> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Deser.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/13/79</u> , 19 <u>79</u> , to <u>Jan 19</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/13/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Simon A. Corfudis</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/21/79</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Simon A. Corfudis</u>						22e. ADDRESS <u>4432 Park Hgts Rd</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <u>Histoy Melindy</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00929

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA F HALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-3-1979</b>			2b. HOUR <b>7<sup>30</sup> PM</b>			
3. SEX <b>Female</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 15 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN — Kenney</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY — Dennis</b>		16. ADDRESS <b>515 N. London Ave.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>218-01-5882</b>		17. INFORMANT <b>Henry C. Kenney Sr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD to congestive heart failure.</b> <b>429.2</b> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 27</b> , 19 <b>78</b> , to <b>Jan 3</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Jan 3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Julian W Reed</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/4/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN W REED</b>			22e. ADDRESS <b>615 CHAS ST. BALTO MD 21230</b>						
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>			23b. DATE <b>1-8-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NAT'L CONST. BALTO.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>— — md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C. Brown</b>			ADDRESS <b>Mortuary 1206-08 W No</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Fifty Kelly</b>	

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12-00022





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00930 REG. NO.			
1. FOR STATE REGISTRAR ENOCH H.				2a. DATE OF DEATH Jan. 30/79			
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ENOCH H. HALL				2b. HOUR 4 <sup>00</sup> P.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR May 1/19/06		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD.	
10. CITY OR TOWN OF DEATH BALT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chaufeur now		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Anne Arundel		13c. CITY OR TOWN BALLOTHIAN	
14. FATHER'S NAME FIRST MIDDLE LAST Hoover COOPER HALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL HOLLARD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-22-1489		17. INFORMANT ADDRESS CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK, RENAL FAILURE</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ESOPHAGEAL CA W MYES</u> POSSIBLE MI, POOR NUTRITION DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>RENAL FAILURE</u>							
19a. DATE OF OPERATION <u>ESOPHAGEAL RESECTION (PREV. ADMISSION)</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ESOPHAGEAL CANCER</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>79</u> , to <u>1/30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S. KOEHLER</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/30/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. KOEHLER</u>				22e. ADDRESS <u>UNIV. HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb. 3-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Chr. Cem</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sunderland Calvert Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Spencer E. Sewell</u>				ADDRESS <u>Prince Frederick, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 5 1979</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

50-00030



UNITED STATES GOVERNMENT  
OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D. C. 20530

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]

Respectfully,  
[Signature]  
[Name]  
[Title]  
[Address]  
[City, State, Zip]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00931  
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE NMI HALL			2a. DATE OF DEATH			MONTH DAY YEAR 01 26 79			2b. HOUR 9:02P M		
3. SEX MALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR 04 18 20			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOCH RAVEN, MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH			13e. STREET ADDRESS 1130 STOCKTON, STREET 21217					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II			16b. SOCIAL SECURITY NO. 220 03 0862			17. INFORMANT ADDRESS SHIRLEY FRANKLIN 1130 STOCKTON ST. 3900 LOCH RAVEN BLVD., BALTO. MD. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive hemophysis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 6 mo.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/> NOT AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3900 LOCH RAVEN BLVD., BALTO. MD. 21218					
22a. I certify that (X) (this hospital) attended the deceased from <u>12-11</u> , 19 <u>78</u> , to <u>1-26</u> , 19 <u>79</u> , that (X) (we) lost saw the deceased alive on <u>1-26-</u> 19 <u>79</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE Andrew P. Fridberg MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/26/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW P. FRIDBERG MD						22e. ADDRESS BALTO. VAH BALTO. MD. 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-1-79			23c. NAME OF CEMETERY OR CREMATORY KING MEN. PK.			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME Dale F. J. A.						ADDRESS 1348 CALHOUN ST.			25a. DATE REC'D. BY REGISTRAR JAN 29 1979		
						25b. REGISTRAR'S SIGNATURE Fridberg					



Items #21a-21f &amp; 22a Film G528

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00932

REG. NO.

FOR  
1- STATE  
REGISTRAR

2/9/79 rc

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MYRTLE F. HAMILTON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/6/79</i>		2b. HOUR <i>1:30 PM</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-13-1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>				13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry T. Stevenson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Corra Brown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>220-44-7421</i>		17. INFORMANT ADDRESS <i>Mrs. Catherine M. Tovey 5705 Whitby Rd. 21206</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advent 2° to fx of 2 ribs &amp; pelvic bone</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>888-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 weeks</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Temporal arteritis, COPD, AODM</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR MONTH DAY YEAR <i>12-25-79</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>Frequent falls 2° to progressive weakness while at Nursing Home</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Long Green N.H.</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Balto., Balto., Md.</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>1/5/79</i> , to <i>1/6/79</i> , that (I) (we) lost s/he the deceased alive on <i>1/5/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R Gold</i>			DEGREE <i>MD</i>			22c. DATE SIGNED <i>1/6/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R Gold MD</i>			22e. ADDRESS <i>Union Memorial Hosp. Calvert + 33rd St</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-9-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto., Balto., Md.</i>		
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc.</i>			ADDRESS <i>6415 Belair Rd.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCready</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. The first step is to identify the problem or question that needs to be addressed.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

 OHMH - 16 25M  
 (VR A 15 (4)) 9/74

 FOR  
 1 - STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

 REG. NO. **79-00933**

1. DECEASED NAME (TYPE OR PRINT) <b>Madeline M. HAMMOND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-4-79</b> 1-4-79			2b. HOUR <b>1:58 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 18 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
12. CITY OR TOWN OF DEATH <b>Baltimore</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>			16b. COUNTY <b>Anne Arundel</b>		16c. CITY OR TOWN <b>Baltimore</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS <b>107 W. 11th. Avenue 21225</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>Adam Malinowski</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Swincinski</b>			19. ADDRESS <b>Anbutus, Maryland 21227</b>				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			21. SOCIAL SECURITY NO. <b>216-03-2728</b>		22. INFORMANT <b>Mrs. Helen Okonski 5538 Willys Avenue</b>					
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute subendocardial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE					
34. I certify that (I) (this hospital) attended the deceased from <b>1-03-1979</b> to <b>1-04-1979</b> , that (I) (we) last saw the deceased alive on <b>1-04-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
35. SIGNATURE <b>S. Pathmanathan</b>			36. DEGREE <b>M.D.</b>			37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		38. DATE SIGNED <b>1-04-79</b>		
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sivakolunthunathan Pathmanathan</b>			40. ADDRESS <b>South Baltimore General Hospital, Baltimore, M.D. 21230</b>							
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			42. DATE <b>1/8/79</b>		43. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		44. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Anne Arundel Md.</b>			
45. FUNERAL DIRECTOR NAME <b>Mc Cully Funeral Home of Brooklyn</b>			46. ADDRESS <b>237 E. Patapsco Avenue Balto., Md. 21225</b>		47. DATE REC'D. BY REGISTRAR <b>JAN 9 1979</b>		48. SIGNATURE <b>[Signature]</b>			

33-0000-01



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 79-00934	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE H. HANKS</b>						2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>1 1 1979</b>		2c. DATE PRONOUNCED DEAD <b>1 1 1979</b>		2d. HOUR <b>12:50</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>28</b> YEAR <b>90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		7b. HOUR <b>a</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2747 EDMONDSON AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Proprietor Barber-Shop</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2747 Edmondson Ave.</b>			
14. FATHER'S NAME FIRST <b>unk</b> MIDDLE <b>unk</b> LAST <b>unk</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Harriett</b> MIDDLE <b>Hanks</b> LAST <b>Hanks</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>213-34-2840</b>		17. INFORMANT ADDRESS <b>Mrs. Martha B. Hanks- Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>ASSISTANT</b> MEDICAL EXAMINER				DATE SIGNED <b>1/1/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>MARGARITA A. KORELL, M.D.</b>				ADDRESS <b>111 PENN ST. BALTO., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co.</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b> ADDRESS <b>3035 W. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCurdy</b>			

12-00034

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR 15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 79-00935

1. FOR STATE REGISTRAR																					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR			
Clara		Marie		Hansely				1		31		19		79				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female		White		Aug. 8, 1901		77 YRS.						1		31		19		79		4:58 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U S A										Baltimore City,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		814 N. Woodington Road		Retired		Drug															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		814 N. Woodington Rd.												21229	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
John		Hansely		Catherine		Grubitz															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT																	
no		212-26-6652		814 N. Woodington Road		21229		Mrs. Wilhelmina McGeehan,													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
4292		DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF																	
		(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Hypothyroidism																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?															
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion													
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Virginia L. Dolan		Assistant		2/1/79																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Virginia L. Dolan, M.D.		111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE															
Burial		2/3/79		New Cathedral Cemetery		Baltimore, Maryland															
24. FUNERAL DIRECTOR NAME		ADDRESS		DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE															
Witzke Funeral Home of Catonsville, P.A.		1630 Edmondson Ave., Catonsville, Md.		FEB 5 1979																	

1608

January

1942-1943

1942-1943

1942-1943

1942-1943

1942-1943

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 79-00936

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH						2b. HOUR					
FIRST MIDDLE LAST Roger Hardy, Sr.						MONTH DAY YEAR 1 26 1979						M					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD						2d. HOUR					
Male	Black	MONTH DAY YEAR 1 22 05	LAST BIRTHDAY 74 YRS.	MONTHS	DAYS	1 26 1979						6:20P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia		U. S. A.				Baltimore City, MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore City		4105 Barrington Road															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4105 Barrington Road									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST James Hardy				FIRST MIDDLE LAST Caroline													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
No				212-10-5912		Rosa Hardy 4105 Barrington Road											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Condition(s), if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Virginia L. Dolan				M.D. Assistant MEDICAL EXAMINER				1/31/79									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Virginia L. Dolan, M.D.				111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				2/1/1979		Md. Nat. Mem. Park				Laurel, Maryland							
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Wm. C. March F/H 1101 East North Ave.						FEB 1 1979		R. H. H. H. H.									

18-00236

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-00937 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie R. Hardy										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 31 1979										2b. HOUR M 1:05P	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2-2-1922		6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 31 1979		2d. HOUR M 1:05P									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.									
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1211 Hollins Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck Driver				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1211 Hollins Street											
14. FATHER'S NAME FIRST MIDDLE LAST Joseph R. Hardy										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hassie Charles											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WWII 239 28 4465		17. INFORMANT ADDRESS Herman Hardy 1029 38th Street Norfolk Va.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 1519 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 2/1/79													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St. Balto., MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-3-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.											
24. FUNERAL DIRECTOR NAME Isaiah L. Brown & Son PA 1913 W. Balto. Md.				25a. DATE REC'D. BY REGISTRAR FEB 6 1979				25b. REGISTRAR'S SIGNATURE Isaiah L. Brown													

78000-02



Info taken from Birth Certificate  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

79-00938

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Michael Harlan</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 15 79</b>		2b. HOUR <b>1045 P</b> M	
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 79</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>✓</b> IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN <b>12 45</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Md.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. COUNTY <b>Calvert</b> 13d. CITY OR TOWN <b>Chesapeake</b>			13e. STREET ADDRESS <b>5138 Schalk Rd. Lineboro CPO</b>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Michael</b> LAST <b>Harlan</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ruth</b> MIDDLE <b>Ann</b> LAST <b>Harlan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO		17. INFORMANT'S ADDRESS <b>Monchester, Md.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> 7468 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aortic and mitral valve atresia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (This hospital) attended the deceased from <b>1/15</b> , 19 <b>79</b> , to <b>1/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and not) view the body after death.					
22b. SIGNATURE <b>Henry A. Bowen M.D.</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry A. Bowen</b>			22e. ADDRESS <b>Univ. of Md. Hosp., Balt., Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>655 W. Balto. St. Balto., Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry A. Bowen</b>

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7a-00038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00939

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAURICE S. HARMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 7, 1979</b>		2b. HOUR <b>12:30<sup>p</sup><sub>M</sub></b>
3 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>615 E. 34th St.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>615 E. 34th St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick D. Harman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Valentine</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-10-3270</b>		17. INTERMENT ADDRESS <b>EDWARD K. HARMAN</b> <b>9324 Waltham Woods Rd. 21234</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Emphysema</b>					
19a. DATE OF OPERATION <b>2/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>5/28/65</b> to <b>1/7/79</b> , that (I) (we) lost <b>28</b> <b>19</b> <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Albert B. Bradley</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>Jan. 8, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert B. Bradley, M.D.</b>		22e. ADDRESS <b>4900 Belair Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 11, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clear Spring, Wash., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	
24. FUNERAL HOME <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> <b>6009 Harford Rd., Balto., Md. 21214</b>					

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1. FOR STATE REGISTRAR

2. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-00940 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Julia M. Harp</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>6</b> YEAR <b>79</b>		2b. HOUR <b>9:00 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>04</b> YEAR <b>95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Gabriel</b> LAST <b>Jacob</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Susan</b> MIDDLE <b>Jacob</b> LAST <b>Jacob</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>1749</b>		17. INFORMANT <b>Mary Robinson 3109 Milford Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SECONDARY METASTASES</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA of BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b> <b>9 years.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PATHOLOGICAL FRACTURE of RIGHT HIP.</b>							
19a. DATE OF OPERATION <b>1/6/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1749</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/21/1978</b> , to <b>1/6/1979</b> , that (I) (we) last saw the deceased alive on <b>1/6/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Franz C. Vella</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/6/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANZ C. VELLA-CAMILLERI</b>				22e. ADDRESS <b>6601 E. English Oak Rd., Baltimore, MD 21234</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balt. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>William C. Brown 1206-28th North Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Fitzroy Kelly</b>	

04200-27

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-00941

1. DECEASED NAME (TYPE OR PRINT)		FIRST EVELYN		MIDDLE V.		LAST HARRIS		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 7 1979		2b. HOUR M 12:24	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1917		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 7 19 79		2d. HOUR P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1800 N. Charles St. Apt. 85				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress, Joel's Restaurant		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1800 N. Charles St. Balto. Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Herman J. Fleming				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Un'known							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 294-12-2671		17. INFORMANT ADDRESS Mrs. Jenny M. Hall, 805 E. Fort Ave. Balto. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Margie Ann Kneel</u>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 1/8/79			
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.						ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 10, 1979		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN Baltimore,		COUNTY Maryland			
24. FUNERAL DIRECTOR NAME McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE Lillian McCurdy							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-00942  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Morris</b>		FIRST <b>MORRIS</b>		MIDDLE <b>HARRIS</b>		LAST <b>HARRIS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1-7-79</b>		2b. HOUR <b>10:45 p.m.</b>	
3. SEX <b>MALE</b>		4. RACE <b>W/WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 15 92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, MD</b>					
10. CITY OR TOWN OF DEATH <b>Balto, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HECHT CO.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>910 E. CHURCH ST. #21801</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID SOLOMON HARRIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HANNAH UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES -</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI-ARMY 212099446</b>		17. INFORMANT <b>MRS. MADELINE G. HARRIS</b> <b>910 E. CHURCH ST. SALISBURY, MD 21801</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (h) (this hospital) attended the deceased from <b>12-27</b> , 19 <b>1978</b> , to <b>1-7</b> , 19 <b>79</b> , that (i) (we) last saw the deceased alive on <b>1-7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Morris Gebremariam</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/7/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Morris Gebremariam</b>						22e. ADDRESS <b>LUTHERAN Hosp</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 9, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

70-00045

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-00943	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR			
EDMOND Edward T. HARRISON						15 19 79		79		A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		Black		1/1/08		71 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
N.C.				U.S.A.				Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Baltimore				University Hospital							
13a. STATE						13b. CITY OR TOWN		13c. STREET ADDRESS			
MD.						City		Box 812 Old Mill Rd.			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Rev. Thomas Harrison						Mary Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
No								Edward T. Harrison Jr. 438 Quackenbos St. N.W. Wash. DC.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute allergic reaction to contrast media											
8588											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
Arteriosclerotic cardiovascular disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				? P.M. 1/15/ 19 79				subsequent to injection of contrast media			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				hospital				University Hosp. Baltimore Md. STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korell, M.D.				Assistant				1/15/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				1/19/79		Cedar Hill Cem.		Brooklyn Md. COUNTY STATE			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles A. Rice 1300 Eutaw Pl.						JAN 24 1979		Dietrich McCreedy			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-00944  
REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH		21. HOUR	
FLORENCE E. HARRON		Jan 29, 79		4 15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	Dec. 15, 1892	86	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	City Hospital, Balto. Md.		Cleaning		City Schools
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1 Henrietta St. Balto. Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Unknown		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-54-1801		Mr. Joseph Harron, Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) cardiorespiratory arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) sepsis					1 wk
DUE TO, OR AS A CONSEQUENCE OF					
(c) severe decubiti, debilitation					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
severe peripheral vascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
1/24/79		gangrene of @ foot		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 1/22, 1979, to 1/29, 1979, that (I) (we) last saw the deceased alive on 1/29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
I Tang				1/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
I. TANG		BCH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 1, 1979		New Cathedral Cemt.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
McGully Funeral Home, 130 E. Fort Ave. Balto. Md.		JAN 30 1979		Ricky McCreedy	

44000-01



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00945

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES E. HARRY			2a. DATE OF DEATH MONTH DAY YEAR 1 4 79		2b. HOUR 12 <sup>30</sup> A M
3. SEX Male	4. RACE Caus.	5. DATE OF BIRTH MONTH DAY YEAR May 18, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Tire Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2122 Druid Park Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Harry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Crawford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) XXXXX YES WW11		16b. SOCIAL SECURITY NO. 234-22-1592	17. INFORMANT ADDRESS Davis Funeral Home, Princeton, West Virginia		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>yr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>history of myocardial infarction, angina pectoris, high blood pressure</u>					
19a. DATE OF OPERATION 9 9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/6/11</u> , 19 <u>79</u> , to <u>1/4</u> , 19 <u>79</u> , that (I) <del>was</del> lost saw the deceased alive on <u>1/4</u> , 19 <u>79</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) view the body after death.					
22b. SIGNATURE <u>Donald J Weglein MD Resident</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/4/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WEGLEIN		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-79	23c. NAME OF CEMETERY OR CREMATORY Oakvale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakvale West, Virginia
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Road Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR 04 JAN 9 1979	25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



24000-02-00042

UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 9 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79-00946 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>Mary</b> <sup>FIRST</sup> <b>M.</b> <sup>MIDDLE</sup> <b>Hartman</b> <sup>LAST</sup>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>14</b> YEAR <b>79</b>		2b. HOUR <b>9:20</b> <sup>PM</sup>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>August</b> DAY <b>10</b> YEAR <b>1883</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1000 S. Caton Ave. Balt., Md. 21229</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3663 MacTevish Avenue</b>	
14. FATHER'S NAME FIRST <b>unknown</b> MIDDLE <b></b> LAST <b>Bothoff</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220-01-29358</b>		17. INFORMANT ADDRESS <b>Mrs. Anne Townsend, 3663 MacTevish Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Intertrochanteric Fracture - Rt. Hip</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b> <b>10 YRS.</b>	
19a. DATE OF OPERATION <b>2-28-78</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intertrochanteric Fracture - Rt. Hip</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <b>(he)</b> (this hospital) attended the deceased from <b>2-28-78</b> to <b>1-14-79</b> , that <b>(we)</b> last saw the deceased alive on <b>1-14-79</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(we)</b> (I) (did) (do not) view the body after death.									
22b. SIGNATURE <b>John F. Hartman</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-15-1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. HARTMAN, M.D.</b>		22e. ADDRESS <b>1000 S. CATON AVE. BALTO MD 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Cetonsville, P.A.</b>		ADDRESS <b>1630 Edmondson Ave., Cetonsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McBrady</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00947  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Helan						Hawkins		1		4	79	M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		Negro		4 8 1901		77		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD		
Virginia		U. S. A.				Baltimore City								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore		Provident Hospital												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3304 Fairview Avenue						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST		FIRST MIDDLE LAST												
Lloyd		Mills		Mary		Drummond								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
		216-28-1644		William Hawkins		3123 Phelps Lane								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		436- Sepsis		DUE TO, OR AS A CONSEQUENCE OF (b)		Urinary Tract Infection		DUE TO, OR AS A CONSEQUENCE OF (c)		Cerebrovascular accident		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		Aspiration pneumonia, suspected												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
		Congestive Heart Failure		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		12:00 P.M.		Falls from a tree										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from		12/8, 1978		to		1/4, 1979		that (I) (we) last saw the deceased alive on		19		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE		DEGREE		22c. DATE SIGNED										
Rifat Aboumy		MD												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Rifat Aboumy														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE		
Burial		1/9/1979		King Memorial Park		Baltimore Co., Maryland								
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Wm. C. March F/H 1101 East North Ave.						JAN 8 1979		Rifat Aboumy						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-00948 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Helen B. Hawkins (Melvin)								January 13, 1979		3:55p M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Negro		9 17 1932		46 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U. S. A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland						Baltimore				2211 Druidhill Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Thomas B. Scott		Helen Husen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
				Clarence Hawkins 2211 Druidhill Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>											
1889 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the bladder with</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rectovaginal fistula</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1/8</u> , 19 <u>79</u> , to <u>1/13</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1/13</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Saied Talaie, M.D.		M.D.						1-13-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
		c/o 827 Linden Ave. Balto. MD. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/18/79		Mt. Auburn Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H		1101 East North Ave.				JAN 17 1979		Hofsky/ACroody			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00949

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Willie Mae Hawkins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/4/79</i>			2b. HOUR M			
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1/23/26</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt City 21012</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Md. Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>		13b. COUNTY <i>BALTO.</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1629 Division St.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Willie PARKER</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Della LYNCH</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <i>Wm. Hawkins 1629 Division St.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Essential Hypertension</i> <i>401X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1966 -</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>Cancer of the Breast - SIP Rt Mammectomy 1977</i>									
19a. DATE OF OPERATION <i>12/20/78</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/20/78</i> to <i>12/20</i> 19 <i>78</i> , that (I) (we) last saw the deceased alive on <i>12/20/78</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE <i>Myrna E. Estroch, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/4/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MYRNA E. ESTROCH</i>				22e. ADDRESS <i>Baltimore City Hosp.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-8-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Aebutus Mem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>BAILEY FUN' HOME 1348 CALHOUN ST.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 9 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>			

7a-00042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00950 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1 4 79			
1. DECEASED NAME (TYPE OR PRINT) <u>MaeJline J. HAZEL</u>				2b. HOUR M			
3. SEX <u>F</u>		4. RACE <u>B</u>		5. DATE OF BIRTH MONTH DAY YEAR 4 1 1894		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>South Carolina</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Lutheran Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Maryland</u>				13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Irvin Hazell 1416 Poplar Grove</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC CORONARY VESSEL DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>~20 YEARS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>13 MINUTES</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>18 DECEMBER 1978</u> , to <u>JANUARY 4, 1979</u> , that (I) (we) lost saw the deceased alive on <u>November 1, 1978</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Nathaniel George Hagler, III</u> DEGREE <u>M.D.</u>				22c. DATE SIGNED <u>1-4-79</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NATHANIEL GEORGE HAGLER, III</u>	
22e. ADDRESS <u>415 DAWRY LN. BALTO., MD. 21229</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/11/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King Memorial Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H 1101 East North Ave.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 16 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Hilary McCreedy</u>	

MEDICAL CERTIFICATION

BP

1a-00320



1a-00320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-00951 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CLARA L. HAZLETT		2a. DATE OF DEATH JAN 27, 79		2b. HOUR 1:58 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 02 07 07		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SIMA HOSPITAL OF BALTO		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEVER WORKED		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO	
14. FATHER'S NAME FIRST MIDDLE LAST DAUGHTERY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-24-3762		17. INFORMANT ADDRESS JANE COLEMAN 424 Philadelphia Rd. 21083	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COMA 2501 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) M.I. + CVA DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic ketoacidosis + SEPSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 27 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 23 May 19 77 to 27 Jan 19 79 that (I) (we) last saw the deceased alive on 27 Jan 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.					
22b. SIGNATURE A.M. LEBSUN M.D.		DEGREE M.D.		22c. DATE SIGNED 27 JAN 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.M. LEBSUN M.D.		22e. ADDRESS 3640 FORDS LANE BALTO MD 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/30/79		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD	
23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO MD		23e. DATE REC'D. BY REGISTRAR FEB 1 1979			
24. FUNERAL DIRECTOR NAME MITCHELL-WIDENFELD/HOME		25b. REGISTRAR'S SIGNATURE Anthony McCurdy			

12000-02

12000-02



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00952 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AMY MARLENE HEALY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 26, 1979</b>			2b. HOUR <b>08:00P</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 6, 1971</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>7</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>406 W. Joppa Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>P. Bruce Healy</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty H. Hoffert</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. P. Bruce Healy Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>1719</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>DISSEMINATED RHABDOMYOSARCOMA</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 22, 19 79</b> , to <b>JAN 26, 19 79</b> , that (I) (we) lost saw the deceased alive on <b>26 JAN 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>Mary J. Murphy, MD</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-26-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARY J. MURPHY</b>						22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTIMORE</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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13-00225

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00953

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FIRST JAMES MIDDLE K. LAST HEALY JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/27/79</b>		2b. HOUR <b>3:48 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>USA</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Airlines</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Rodgers Forge</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>163 Dumbarton Rd.</b>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>K.</b> LAST <b>Healy SR.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Laura</b> MIDDLE <b>Gau</b> LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>W.W.11</b>		16b. SOCIAL SECURITY NO. <b>219-18-6498</b>	
17. INFORMANT <b>Elizabeth Healy</b>		ADDRESS <b>Same</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESP. ARREST</b> 1919 DUE TO, OR AS A CONSEQUENCE OF (b) <b>TERMINAL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GLIOBLASTOMA (BRAIN CA)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>3/78 &amp; 7/78</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GLIOBLASTOMA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> , 19 <b>79</b> , to <b>1/27</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Sanchez</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. SANCHEZ</b>		22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/31/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Balto Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 Tork Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>FFR 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00954 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Baby Boy Helmick				2a. DATE OF DEATH MONTH DAY YEAR 1 21 79 2b. HOUR 8:21a.m.			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 20 79		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 11 34	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTO				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3431 LYNDALE			
14. FATHER'S NAME FIRST MIDDLE LAST FRANCISCO A. GUZMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DEBRA HELMICK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT PARENTS		ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 7700 } DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Pneumonia (c) most probably Group B Strep DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-20-19-79, to 1-21-19-79, that (I) (we) lost saw the deceased alive on 1-20-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Abdalla				DEGREE 2ndy ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAGDA ABDALLA				22e. ADDRESS MERCY Hosp. 301 St Paul Place			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/25/79		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE				25a. DATE REC'D. BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

72000-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										79-00955	
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LUCY D. HEMBY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 28 79</b>				2b. HOUR <b>M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 18 1881</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4014 DUVAL AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4014 DUVAL AVENUE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN DUGGER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>238-26-7966</b>		17. INFORMANT ADDRESS <b>JOYCE LEA 4014 DUVAL AVENUE</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1-27</b> , 19 <b>79</b> , to <b>1-30</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1-27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>HATTIE MAE LEATH-GAINES, MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/30/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HATTIE MAE LEATH-GAINES, MD</b>				22e. ADDRESS <b>1701 W. PRATT ST BALTO., MD 21223</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROWN HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>GREENVILLE NORTH CAROLINA</b>					
24. FUNERAL DIRECTOR NAME <b>ARLINGTON S. PHILLIPS</b>				ADDRESS <b>1721-27 N. MONROE STREET</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Betty McCreedy</i>			

78-00222



COLLECTION

EDWARD





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00956

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Margaret H. Hemling</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>18</b> YEAR <b>79</b>			2b. HOUR <b>8:23</b> PM					
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH <b>6</b> DAY <b>25</b> YEAR <b>99</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.			
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1453 Kitmore Road 21239</b>		
14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Steigerwald</b> LAST <b>John</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Ament</b> LAST <b>Mary</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-07-2387D</b>	
17 INFORMANT <b>Katherine DiLeonardi (dgr)</b>			ADDRESS <b>same as 13</b>			18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Infarcted Myocardial Infarction</b> <b>440-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <b>1/13</b> , 19 <b>79</b> , to <b>1/18</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>S. Gail Wilson, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/18/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Gail Wilson, M.D.</b>						22e. ADDRESS <b>Good Samaritan Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR <b>Schumnek Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7a-00026



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M7/77  
(VR 415 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00957 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUGUSTA M. HENRY				JANUARY 17, 1979				2:08 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home & Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Julius ----- Yanke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilhemina ----- Kintop Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-14-5013		17. INFORMANT ADDRESS Mr. William Yanke, 2502 Palomino Ct. Finksburg					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 2864 } DUE TO, OR AS A CONSEQUENCE OF b) Von Willebrand's Disease c) } DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITUS									
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NO INJURY					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 1-14, 19 79, to 1-17, 19 79, that (I) we lost saw the deceased alive on 1-17, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE K. George Thomas				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-17-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. GEORGE THOMAS, M.D.				22e. ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY, BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME McGully Funeral Home, 130 E. Fort Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR JAN 23 1979		25b. REGISTRAR'S SIGNATURE J. J. H. H.			

MEDICAL CERTIFICATION

29

BP

72000-02

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

10/1/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00958 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
FIRST MIDDLE LAST Sallie L. Henry				2a. DATE OF DEATH MONTH DAY YEAR 1 16 79			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 31 99		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Patricia Bowman 1318 N. Carey St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 402- Conditions, if any, which gave rise to immediate cause (b) <u>Cardiac arrhythmia</u> c) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) N/A							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> , 19 <u>79</u> , to _____, 19 _____, that (I) (we) lost saw the deceased alive on <u>8:12 pm Jan 16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Raymond Doyle MO				DEGREE		22c. DATE SIGNED 1-19-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND Doyle MO				22e. ADDRESS Provident Hospital BALT. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 22 1979	
				25b. REGISTRAR'S SIGNATURE Patricia Bowman			

Hypocistis carolinensis  
Carpus carolinensis  
Carpus carolinensis

1/11  
1/11

X

Raymond Dole MO  
Raymond Dole MO

Raymond Dole MO  
Raymond Dole MO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 79-00959			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Brandy L. Henson</b>										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>1 24 1979</b>		2b. HOUR M <b>4:35A</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10/17/78</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN. <b>3</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 24 1979</b>		2d. HOUR M <b>4:35A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2139 Homewood Avenue</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Larry Henson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Church</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Larry Henson 2139 Homewood Avenue</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>						TITLE (SPECIFY) <b>M.D. Deputy Chief</b>			DATE SIGNED <b>1/24/79</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>						ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Joppa, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Larry Henson</i>					



12-00000

12-00000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												79-00960 REG. NO.	
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Francis L. Herbert</b>						2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 23 1979</b>		2b. HOUR <b>5:50P M</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>52 YRS.</b>		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 23 1979</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1800 Division Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clifton Dorsey</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Herbert</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>219-12-4896</b>		17. INFORMANT ADDRESS <b>Laura Herbert 1800 Division Street</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple gunshot wounds</b> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>5:30 P.M. 1 23 1979</b>				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>5:30 P.M. 1 23 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>shot by assailant</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Laundromat</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1801 Pennsylvannia Ave. Balto MD.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>						TITLE (SPECIFY) <b>Deputy Chief</b>		DATE SIGNED <b>1/24/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>						ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH **79-00961**

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 2 19 79										2b. HOUR 8:16 P.M.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST													
GEORGE		SYLVESTER		HERL															
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		8. 1 2 19 79					
Male		White		AUG. 19, 1902		76 YRS.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City							
BALTIMORE, MD.				U.S.A.								MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				3819 Foster Avenue								RETIRED				BETH STEEL CO.			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MD.				-----				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3819 FOSTER AVE. # 21224.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
GEORGE F. HERL				ROSE E. ZEBERLEIN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN?)				16b. SOCIAL SECURITY NO.				17. INFORMANT											
NO				213-09-1683A				JUANITA BRADY : ADDRESS 6215 MARGLENN RD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right traumatic pneumothorax</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 2 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) fall at home											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3819 Foster Avenue Baltimore, Maryland											
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief, MEDICAL EXAMINER								DATE SIGNED 1/3/79							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Thomas D. Smith, M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				1-6-79				HOLY REDEEMER CEM.				4430 BELAIR Rd., BALTO., MD.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Charles S. Geiler + Son				6224 EASTERN AVE. BALTO., 21224, MD.				JAN 10 1979				History McCready							

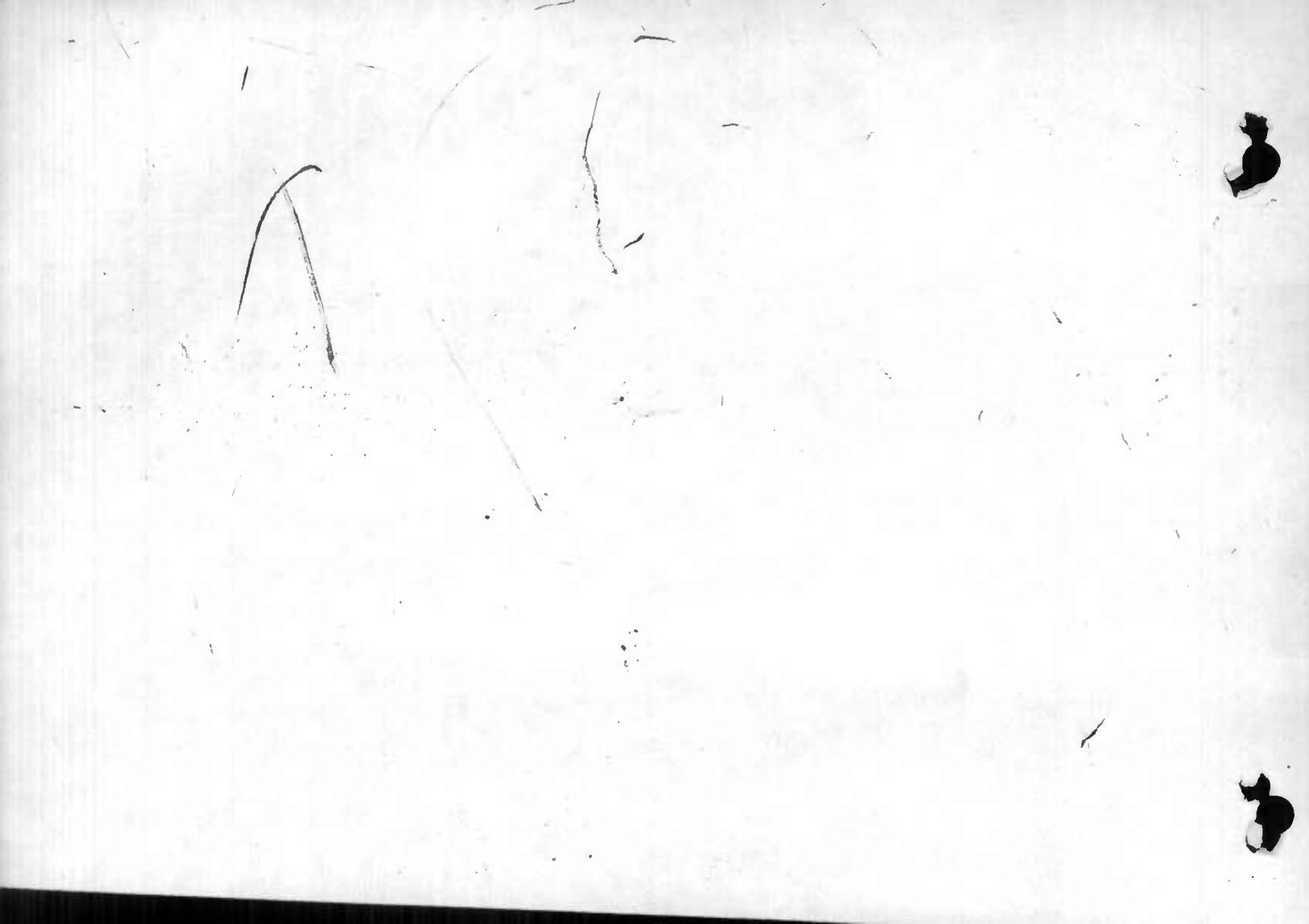
10-00001

VOIDED DEATH CERTIFICATE NUMBER 79-00962

SEE FLORINE L. HEROLD, DEC. 31, 1978, CITY

BACK OF ~~THE~~ DEATHS.

*See Certificate* 78-32420





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00963 REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
		George * E Hervey				1 14 79				2 P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		3/13/85		93		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
W. VA.		USA				Balt. City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balt. City		Balt. City Hosp.				STEEL					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
M.D.				BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6501 CLEVELAND			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
UNK				UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
NO				213073589		JAMES HERVEY		6926 SOLLERS PI. RD			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a): Resp. Arrest											
436- DUE TO, OR AS A CONSEQUENCE OF											
(b) <del>CHANCE</del> possible CVA										1/9/79	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 12/8/78, 19____, to 1/14, 1979, that (1) (we) lost saw the deceased alive on 1/14/79, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Paul Fishman				M.D.				1/14/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Paul Fishman				B. C. H.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL				1/18/79		OAK LAWN		BALTO.		M.D.	
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Connelly F.H.				JAN 18 1979							
300 Mace ave											

78-000003



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-00964

FOR 1 - STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLIFFORD F Hicks.					2a. DATE OF DEATH MONTH DAY YEAR 1 17 79					2b. HOUR 6:30 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 25 20		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2533 W. Baltimore St 21223			
14. FATHER'S NAME FIRST MIDDLE LAST Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tibola Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-16-353P		17. INFORMANT ADDRESS HARRIET Hicks 2533 W Baltimore St 21223							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. DUE TO, OR AS A CONSEQUENCE OF (b) cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) A.D.S.C.D.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-10-79 to 1-18-79, that (I) (we) lost saw the deceased alive on 1-18-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Agustin del Campo MD		DEGREE		22c. DATE SIGNED 1-18-79				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Agustin del Campo		22e. ADDRESS Bon Secours Hosp. Balt. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-20-79		23c. NAME OF CEMETERY OR CREMATORY King Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME JAMES A. MORTON & Sons		ADDRESS 1701 LAURENS		25a. DATE REC'D. BY REGISTRAR JAN 22 1979		25b. REGISTRAR'S SIGNATURE Ruthy A. Cready					

1a-00004

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-00965  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY E. HICKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 3, 1979</b>			2b. HOUR <b>9:55 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 / 22 / 87</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Brunswick Co. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PARK HILL NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1830 E. Chase St. 21213</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM — EVANS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217.0118-82</b>		17. INFORMANT ADDRESS <b>David Hicks - 1830 E. Chase St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Block with pacemaker</b> <b>4269</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Adrenal failure</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-25, 1977</b> , to <b>1-3, 1979</b> , that (I) (we) lost saw the deceased alive on <b>1-3, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>E. Ellsworth Cook</b> MD						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-4-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Ellsworth Cook MD</b>						22e. ADDRESS <b>2431 Maryland Ave. Balt. MD 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>A.A. County MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>ELICKSON F.H. - 1129 N. Caroline St.</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 5 1978</b>		25b. REGISTRAR'S SIGNATURE <b>D. J. Kelly</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

20000-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00966	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Willie Hicks</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>1-16-79</i>		2b. HOUR <i>12:45</i> M			
3. SEX <i>MALE</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCT-19-18</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7. BIRTHPLACE (STATE OR FOREIGN) <i>SOUTHAMPTON CO Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, Md.</i> MD.					
10. CITY OR TOWN OF DEATH <i>Balti.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>				13b. COUNTY		13c. CITY OR TOWN <i>Balti.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>131 N. Fulton Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Hicks</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Isabelle Diggs</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>				16b. SOCIAL SECURITY NO. <i>224-07-7853</i>		17. INFORMANT ADDRESS <i>EDWARD HICKS 3308 BROWN ST. N.W. WASHINGTON, D.C. 20004</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Massive intra Cranial Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>H.S.C.U.D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5 14 19 79</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-16-79</i> to <i>1-16-79</i> , that (I) (we) last saw the deceased alive on <i>1-16-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Agustin del Campo</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>1-16-79</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AGUSTIN DEL CAMPO</i>						22e. ADDRESS <i>Bon Secours Hosp. BALT. MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>1-20-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CARVER MEM. CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SUFFOLK VIRGINIA</i>			
24. FUNERAL DIRECTOR NAME <i>LEROY O. DYETT</i>						ADDRESS <i>4600 LIBERTY HIGTS. AV.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 17 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia Kelly</i>	

MEDICAL CERTIFICATION

99

1901



13-00000

White

Sub-Station

EDWARD HIGGS

111

1-1-19 CHURCH STREET NEWCASTLE

1-1-19 CHURCH STREET NEWCASTLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00967  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Ruth Agnes Hilbert		Jan. 8, 1979		3:28 PM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	89 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA		Baltimore City MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Wesley Home, Inc.		housewife		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.			BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		2211 W. Rogers Ave	
Ernest Hepting		Elizabeth Engle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-05-4380		Pt's Chart	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease					10 years
4292 DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 7/1 1978 to 1/8 1979, that (1) (we) last saw the deceased alive on 1/5 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
James H. Biddison, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
J Biddison		Wesley Home, Balto, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		1/11/79	Western Cemetery		BALTO - MD
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Burgee Funeral Home		3631 Falls Rd.		JAN 11 1979	
				25b. REGISTRAR'S SIGNATURE	
				Fitzpatrick	

78-00000

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										79-00968	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
CHANNIE					HILL					8:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		BLACK		8 18 1902		76		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Georgia		U. S. A.				Baltimore				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Sinai Hospital									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
					Mattie Norris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
							Grace Barnes 2654 Park Heights Terr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Renal Failure - terminal uremia</u> (c) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/29, 19 78, to 1/1, 19 79, that (I) (we) lost saw the deceased alive on 1/1, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Christine L. Myun Han M.D.						DEGREE HOUSE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				1/6/1979		King Memorial Park		Baltimore Co., Maryland			
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H 1101 East North Ave.								JAN 3 1979		L. H. Kelly	

MEDICAL CERTIFICATION

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00969

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Claudia Hill</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 30 79</b>			2b. HOUR M <b>AM</b>	
3. SEX <b>Male Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 27 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2630 E. Preston Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2630 E. Preston Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jim Hill</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Janie McClurkin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-12-2258</b>		17. INFORMANT ADDRESS <b>East Org. NJ</b> <b>Harry Hill 549 N. Grove St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis Coronary Heart Disease 8 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus 10 yrs</b> Approximate interval between onset and death: <b>Instant</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this person) attended the deceased from <b>6-1-68</b> 19 <b>68</b> , to <b>1-30-79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-25-79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eugene H. Owens</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-1-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene H. Owens</b>				22e. ADDRESS <b>1735 E. Federal St</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Linkay McCreedy</b>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-00970 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
DORA CATHERINE HILL			JANUARY 18 1979		11:15 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	WHITE	FEB. 12, 1897		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE, MD.	U.S.A.			BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE, MD.	JOHNS HOPKINS HOSPITAL		RETIRED		HOUSE WORK.
13a. STATE			13b. COUNTY	13c. STREET ADDRESS	
MD.			BALTIMORE	314 IMLA ST. # 21224.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FRANK FLAMM			MARY ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.	17. INFORMANT	
NO			218-30-7211	1960 FRAMES RD. DORIS DAVIS : DUNDALK, 21222, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRAIN STEM DYSFUNCTION</u> 1919 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <u>HIGH grade glioma</u> Unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 1 hr.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
1/1/79		change mental status, tumor on brain, PMIS seen		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1/79</u> to <u>1/1/79</u> , that (I) (we) last saw the deceased alive on <u>1/1/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>11:15 pm.</u>					
22b. SIGNATURE <u>T. Sanchez</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>T. SANCHEZ</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		1-22-79	OAK LAWN CEMETERY	7225 EASTERN BLVD., BALTO., MD.	
24. FUNERAL DIRECTOR NAME <u>Charles S. Geiler &amp; Son, Inc.</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 26 1979</u>		
6224 EASTERN AVE. BALTO., 21224, MD.			25b. REGISTRAR'S SIGNATURE <u>Richard K. Brady</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00971			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Sanford Hill				2a. DATE OF DEATH MONTH DAY YEAR 1 18 79			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 7 1894		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dir. of Research		12b. KIND OF BUSINESS OR INDUSTRY Pulp & Paper	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Ruxton		13e. STREET ADDRESS 1507 Dunlora Rd. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST William Barlow Hill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-6586		17. INFORMANT ADDRESS Harold S. Hill, Jr.--Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C. & Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks 10 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 16, 1978, to Jan 16, 1979, that (I) (we) last saw the deceased alive on Jan 12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Allan Spier		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ALLAN SPIER		22e. ADDRESS 700 W. 40th St. BALTIMORE MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/20/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc.		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 23 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00972

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Michelle A. Hines</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>12</b> YEAR <b>79</b>			2b. HOUR <b>7:40 AM</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH DAY <b>8</b> MONTH <b>30</b> YEAR <b>76</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2 yrs.</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.						
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1046 Parksley Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>-</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1046 Parksley Avenue</b>		
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>J.</b> LAST <b>Hines</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Donna</b> MIDDLE <b>M.</b> LAST <b>Schlotthober</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>-</b>				16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>MARY SCHLOTTHOBER, 1046 PARKSLEY AVENUE</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY/CARDIOVASCULAR ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MINUTE</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>SACRO COCCYGEAL TERATOMA</b>	
		(c) <b>-</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>NOV. 9, 1978</b> to <b>JAN 8, 1979</b> , that (1) (we) lost above, (0) we (did) (did not) view the body after death.							
22b. SIGNATURE <b>Fauzia F. Quddus MD</b> DEGREE <b>MD</b>						22c. DATE SIGNED <b>Jan 12 '79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FAUZIA F. QUDDUS MD</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL 201, NORTH BROADWAY, BALTIMORE MD 21205</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>01-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <i>P. J. Kelly</i>	

78-00975



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-00973

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>ANNA Christine Hoffmeister</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1/11/79</b>		2b. HOUR <b>12:30 PM</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 28 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Franklin Sew</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Swingler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Heintz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-30-2178</b>		17. INFORMANT ADDRESS <b>Dorothy Samek 9 Homberg Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DISSEMINATED INTRAVASCULAR</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COAGULOPATHY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W. Healy MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. HEALY</b>		22e. ADDRESS <b>BCH</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Luth. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Golden Ring Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

99

1



78-00873



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00974

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		01 06 79		11 <sup>45</sup> P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUC.		MONTH DAY YEAR		79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD.		U.S.				BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO		BON SECOURS HOSP		PAINTER		SELF-EMPLOYED	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		2644 NORLAND ROAD, 21230			
HENRY J. HOHMAN		CAROLINA OST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		218-42-5475		ALICE HANSSEN, 2644 NORLAND ROAD, 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION							
DUE TO, OR AS A CONSEQUENCE (b) 410- ST - Temporary Pacemaker							
DUE TO, OR AS A CONSEQUENCE (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 1-4-1979 to 1-6-1979, that (1) (we) last saw the deceased alive on 1-6-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
ABDUL SAMAN KHAN		MD				1-6-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
ABDUL SAMAN KHAN		BON SECOURS HOSPITAL BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		01-10-79		LOUDON PARK		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		21229 JAN 8 1979			

18-00914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00975 REG. NO.					
1. FIRST MIDDLE LAST IDA KELLAND				2a. DATE OF DEATH MONTH DAY YEAR 1/8/78 79				2b. HOUR 100 M	
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 24 05		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balto City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gus Holly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 2438 Shirley Ave.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-32-0248		17. INFORMANT ADDRESS Mrs. Beatrice Golder 5609 Cadillac Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter-cranial hemorrhage</u> 431- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 1/2/78, 19 78, to 1/8, 19 79, that (the) last saw the deceased alive on 1/8, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Neil Warrnes M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/8/78	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Warrnes				22e. ADDRESS Sinai Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-12-79		23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Samuel T. Redd				ADDRESS 5209 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

BP

78-00012

RECEIVED

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

DATE: 10/10/78

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00976			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST M. LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
VIRGINIA		HOLMES		JAN 1, 1979		905 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		W		7 29 11		67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Mount Sinai Hospital		Housewife		Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		395 Westside Drive	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Lionel Morris				Nora B. McDonald			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		579-68-6143		William H. Holmes III Same as 13 a-e			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Sepsis</u>							
4369 DUE TO, OR AS A CONSEQUENCE OF <u>decubitus ulcer</u>							
(b) <u>probable</u>							
DUE TO, OR AS A CONSEQUENCE OF <u>CVA</u>							
(c) <u>CVA</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>probable ca - 10 site unknown</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> , 19 <u>78</u> , to <u>1-1</u> , 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>1-1</u> , 19 <u>79</u> , and that in (my <input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<u>Sigrid Ulrich</u>		MD		1-1-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
SIGRID ULRICH		SINAI HOSP OF BALT.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		1/2/79		Lee's Crematorium		Wash. District of Columbia	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home		Clinton, Md.		JAN 2 1979		<u>Henry Holmby</u>	



78-00976

10-10-78

X

10-10-78

Virginia

10-10-78

10-10-78

10-10-78

Belmont

10-10-78

X

10-10-78

Virginia

10-10-78

Belmont

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no

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10-10-78

10-10-78

10-10-78

10-10-78

Virginia

10-10-78

10-10-78

10-10-78

Belmont



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00977 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN B. HOLSTEIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 4, 1979</b>		2b. HOUR M			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 22, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4311 Valley View Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam B Holstein</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura E Priller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-09-1991</b>		17. INFORMANT ADDRESS <b>Mrs Loretta Young 2920 Fleetwood Ave</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Emphysema</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 19 <b>76</b> , to <b>1-4</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12-21</b> , 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jaime Punzalan</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-4-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jaime M. Punzalan</b>				22e. ADDRESS <b>5508 Belair Rd., Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1978</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

75000-01

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00978

REG. NO.

1- FOR  
STATE REGISTRAR *Owen*

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Owen K. Holt</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 13 79</i>			2b. HOUR MIN. <i>2:30 AM</i>			
3 SEX <i>Male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>02 28 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Balt.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Mail Carrier/Post Office</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY CITY OR TOWN <i>Maryland Annapolis Pasadena</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET DOOR NO. <i>1563 Wall Drive</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>William Holt</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>				16b. SOCIAL SECURITY NO. <i>213 09 9923</i>		17. INFORMANT <i>Pasadena, Md. 21122 Mrs. Elizabeth M. Holt 1563 Wall Drive</i>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cause of heart</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <i>12/20/78</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Airway obstruction</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>1563 Wall Drive Baltimore City Maryland</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/20/78</i> 19 <i>78</i> to <i>1/13</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>1/13</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jessica B. Orenstein</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/13/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jessica B. Orenstein</i>						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1/16/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Anne Arundel Md.</i>		
24. FUNERAL DIRECTOR <i>Mountain and Hick Roads McCreely Funeral Home of Pasadena</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Pitney McCreedy</i>	

15 38 35 120 2 MEDICAL CERTIFICATION 9 9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

79-00978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00979 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET E. HOOK</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 20, 1979</b>			2b. HOUR <b>6:20a. M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 4 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN <b>0 0</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
13. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MARYLAND GENERAL HOSPITAL</b>				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Statistician</b>			16. KIND OF BUSINESS OR INDUSTRY <b>Public Health</b>		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Md</b>		17b. COUNTY <b>-</b>		17c. CITY OR TOWN <b>Baltimore</b>		17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17e. STREET ADDRESS <b>2211 W. Rogers Avenue</b>			
18. FATHER'S NAME FIRST MIDDLE LAST <b>William Allen Hook</b>				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary V. Evans</b>							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				21. SOCIAL SECURITY NO. <b>579 60 09907</b>		22. INFORMANT ADDRESS <b>The Wesley Home 2211 W. Rogers Avenue 21209</b>					
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>STAPHYLOCOCCAL SEPSIS</b> <b>0381</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CONJESTIVE HEART FAILURE. AORTIC STENOSIS. HIATAL HERNIA.</b>											
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
31. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE							
34. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>January 13</b> , 19 <b>79</b> , to <b>January 20</b> , 19 <b>79</b> , that (I) <del>XX</del> lost saw the deceased alive on <b>January 20</b> , 19 <b>79</b> , and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>XX</del> did <del>XXXXXX</del> view the body after death.											
35. SIGNATURE <b>Harold Bob M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						36. DATE SIGNED <b>1/20/79</b>					
37. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD BOB, M.D.</b>						38. ADDRESS <b>7220 Park Heights Ave. Balto. MD 21208</b>					
39. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		40. DATE <b>1/23/79</b>		41. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		42. LOCATION CITY OR TOWN COUNTY STATE <b>Westview Balto. Md</b>					
43. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home 3631 Falls Road 21211</b>						44. DATE REC'D. BY REGISTRAR <b>JAN. 23 1979</b>		45. REGISTRAR'S SIGNATURE <b>D. J. [Signature]</b>			

10-00010

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00980 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
		CHARLES LYNN HOOPER, SR.				January 11, 1979				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Oct. 9, 1923		55		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Tenn.		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Union Memorial Hospital				Maintenance - Crown Cork*Seal					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5011 Harford Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
James		Arthur		Hooper		Jammie		Hurt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		415-22-3967		Katherine L. Hooper 5011 Harford Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										Hours	
410- DUE TO, OR AS A CONSEQUENCE OF										YRS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from 30 Oct 78 to 10 Jan 79, that (1) (we) lost saw the deceased alive on 10 Jan 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. All (we) (I) (did) not view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		10 Jan 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Richard D. Biggs, M.D.		7401 Osler Drive Towson, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE			
Entombment		Jan. 15, 1979		Lorraine Park Maus.		Baltimore		Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
NAME		ADDRESS				JAN 12 1979		D. J. Ruck, Inc.			
Leonard J. Ruck, Inc. Baltimore, Maryland											



19-00880

January 11, 1979

HOOPER, JR.

THINK

CHARLES

Oct. 9, 1963

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Missouri City

U. A.

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Missouri - Grand Jury

Union National Bank

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Katherine I. Hooper, 1963 Missouri

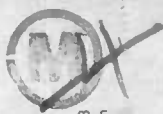
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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00981

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
		Edith Louise Hooper		Female		White		April 7, 1922		56		Maryland		U.S.A.				Baltimore City		Baltimore		4340 Falls Road		Floor lady		Tooth Brush Co			
		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																			
		Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4340 Falls Road																			
		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																									
		Edward Hooper		Elizabeth																									
		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																					
		No		213 16 0691		John Edward Brannen		Same																					
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		sudden																					
		4292		DUE TO, OR AS A CONSEQUENCE OF		Arteriosclerotic Cardiovascular		6 yrs																					
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF		Chronic Spinal Disor		6 yrs																					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																											
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																					
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																							
				P.M. 19																									
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
		22a. I certify that (I) (the hospital) attended the deceased from 4/16/73 19_____, to Present 19_____, that (I) (we) last saw the deceased alive on 1/10/79 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED																					
				Dr. John R. Davis		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/24/79																					
		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																									
		Dr. John R. Davis		401 Medical Arts Building Baltimore																									
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE																					
		Burial		25 Jan. 79		Warfieldburg Cemetery		Westminster Carroll Co. Md.																					
		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																							
		Burgee Funeral Home		3631 Falls Road		JAN 25 1979		Anthony McCroskey																					

18000-02

January 22, 1973

With other people

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Part 1, 1973

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-00982 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH
Grace				Hooper	MONTH DAY YEAR
3 SEX		4 RACE		5 DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female		White		Jan. 10, 1899	79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		UNION MEMORIAL HOSPITAL		Assist. Principal School	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Alcaeus		Florence Gees		No	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours days days	
Wm. J.D. Somerville		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCVD		19a. DATE OF OPERATION	
Baltimore, Md. 21210				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (my hospital) attended the deceased from 12/26/78, 19, to 1/2/79, 19, that (I) (we) last saw the deceased alive on 1/2/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE William L. Higgins		22c. DATE SIGNED 1/2/79	
22b. SIGNATURE William L. Higgins		22c. DATE SIGNED 1/2/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Union Memorial Hospital, Balt Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
22e. ADDRESS Union Memorial Hospital, Balt Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 6, 1979		Druid Ridge	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Pikesville, Balto. Co., Md.		Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md.		JAN 10 1979	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

52-0000-25

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE —  
CERTIFICATE OF DEATH

79-00983  
REG. NO.

FOR 1- STATE REGISTRAR			
1. DECEASED NAME (TYPE OR PRINT) Col. Edward S. HOPKINS		2a. DATE OF DEATH MONTH DAY YEAR JAN. 17, 1979	
3 SEX Male		2b. HOUR 4:50 P M	
4 RACE White		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1896		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consulting Engineer--City		12b. KIND OF BUSINESS INDUSTRY Balto.	
13a. STATE Md.		13b. COUNTY Balto.	
13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Hopkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie B. Maxwell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 217-26-2797	
17. INFORMANT Mrs. Louise Hopkins		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 494- CARDIO-PULMONARY COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONITIS - MULTIPLE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRONCHIECTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 18, 1978, to JAN. 17, 1979, that (I) (we) last saw the deceased alive on JAN. 17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE M. Isabelle Macgregor M.D.		22c. DATE SIGNED 1-17-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Isabelle Macgregor		22e. ADDRESS 11 E. Chase St. Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/79	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR JAN 19 1979	
25b. REGISTRAR'S SIGNATURE H. J. McCreedy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



88200-27

• 1997 •



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										78-00984	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE ANNE HOSFELD						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 18 19 79		2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug 28, 1900		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 18 19 79	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1308 W. 40th St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
13a. STATE Md				13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1308 W. 40th Street	
14. FATHER'S NAME FIRST MIDDLE LAST David Wheeler						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Foley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 220 46 9489		17. INFORMANT ADDRESS James Kleinfelter 1206 W. 40th Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan MD				TITLE (SPECIFY) Assistant				DATE SIGNED 1-19-79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/22/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore			
24. FUNERAL DIRECTOR NAME Burgee Funeral Home				ADDRESS 3631 Falls Road 21211				25a. DATE REC'D. BY REGISTRAR JAN 23 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

12-00084



[Faint, mostly illegible text and markings throughout the page, including a large rectangular box on the right side and various lines of text at the bottom.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-00985		
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR		
VERNON		L.		HOSFELD				DATE ESTIMATED		1 15 1979		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male	White	Mar. 31, 1900		78 YRS.						1 15 1979		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Maryland		USA		WIDOWED		DIVORCED		Baltimore City				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		1308 W. 40th Street				Electrician		Construction				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1308 W. 40th Street			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST				FIRST MIDDLE LAST								
Henry Hosfeld				Cora Barnhart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no				215 09 5998		Florence A. Hosfeld 1308 W. 40th Street						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease												
4292 } DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				
Margarita A. Korell				Assistant				1/15/79				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Margarita A. Korell, M.D.				111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		1/18/79		Druid Ridge Cemetery		Pikesville, Balto. Md						
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Burgee Funeral Home 3691 Falls Road 21211						JAN 16 1979		Petry Melrody				

28200-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00986			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Millis Houghton				2a. DATE OF DEATH MONTH DAY YEAR 1- 31-79		2b. HOUR 11:28 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 16 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boston Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofier		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine		13e. STREET ADDRESS 2225 Gillis Road	
14. FATHER'S NAME FIRST MIDDLE LAST Frances Houghton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lettie Hurd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-01-8142		17. INFORMANT ADDRESS Ollie E. Houghton, Same As #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 5751 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cholecystitis</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week. 3 weeks							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 19 <u>79</u> , to <u>1-31</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1-31</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Harold MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Harold MD</u>				22e. ADDRESS <u>Mercy Hospital. Balt. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-5-1979		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md.	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25. DATE RECD. BY REGISTRAR FEB 6 1979			

38000-27

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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Approved: \_\_\_\_\_  
Special Agent in Charge  
U.S. Department of Agriculture  
Bureau of Plant Industry  
Washington, D.C.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00987

FOR  
1. STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>John P. Housley</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>9</b> YEAR <b>79</b>		2b. HOUR <b>1:40 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>23</b> YEAR <b>95</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b CITIZEN OF WHAT COUNTRY? <b>U S A</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Hospital</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Catonsville</b>	
14 FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>Duncan</b> LAST <b>Housley</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Disney</b> LAST <b>Disney</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>705-03-9458</b>		17 INFORMANT ADDRESS <b>21228 Mr. Charles E. Carroll, 2 Winstead Ct.</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recent myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Ht Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Acute Appendicitis</b>					
19a. DATE OF OPERATION <b>1/9/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if this hospital) attended the deceased from <b>Jan 9, 1979</b> to <b>Jan 9, 1979</b> , that (we) lost saw the deceased alive on <b>Jan 9, 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (s) (did) did not view the body after death.					
22b. SIGNATURE <b>WM Beaven</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/9/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WM BEAVEN</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Glen Burnie, M.A., Maryland</b>		23e. COUNTY <b>M.A.</b>		23f. STATE <b>M.A.</b>	
24 FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville, P.A.</b>		24b. ADDRESS <b>1630 Edmondson Ave., Catonsville, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>		25c. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



78000-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. The appropriate checkboxes should be filled in by the funeral director. Pages 1 through 4 should be attached to the death certificate and retained by the funeral director. The funeral director should be notified of the death of the deceased by the attending physician or the medical examiner.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 16-12 78 79-00988			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BABY BOY HOVLAND</b>				JANUARY 19 1979 12:35A			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 12 1978</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS YRS. MONTHS DAYS HOURS MIN. <b>1 7</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>PASADENA</b>		13c. CITY OR TOWN <b>PASADENA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ERIC HOVLAND</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CAROL HABERMAN</b>		13e. STREET ADDRESS <b>502 BRICE ROAD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GARDIAC FAILURE</b> <b>0384</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GRAM NEGATIVE SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HRS.</b> <b>5 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>PREMATURITY, RDS, SHOCK, HEMOLYSIS, HEPATOMEGALY, ASCITES</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> , 19 <b>78</b> , to <b>1-19</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1-19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas E. Harper</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>01/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS E. HARPER</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/24/79</b> <b>4/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>655 W. Balto. St. Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Ritony McCreedy</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00989

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elmer Howard.</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>26</b> YEAR <b>79</b>			2b. HOUR <b>M</b>					
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>22</b> YEAR <b>03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>		IF UNDER 24 HRS. HOURS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Federal Hill Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shipping Clerk</b>		12b. NAME OF BUSINESS OR INDUSTRY <b>Norman</b>			
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3204 Auchentoroly Terr.</b>		
14. FATHER'S NAME <b>Jacob</b>				MIDDLE <b>Howard</b>		15. MOTHER'S MAIDEN NAME <b>Susie</b>				MIDDLE <b>Matthews</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-05-6954</b>		17. INFORMANT <b>Miss Dorothy Howard- Same</b>			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Lung Carcinoma.</b> DUE TO, OR AS A CONSEQUENCE OF (b). <b>@ CVA.</b> DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/3/79</b> , 19____, to <b>1/26/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>1/26/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. J. Folken</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/27/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.T. Folkemer</b>				22e. ADDRESS <b>Federal Hill Nurs. Home</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>						ADDRESS <b>3035 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby McCreedy</b>	

72-00082



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00990 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Grace Turner Howell</b>						2a. DATE OF DEATH MONTH <b>January</b> DAY <b>6</b> YEAR <b>1979</b>			2b. HOUR <b>6:50 P.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>22</b> YEAR <b>1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b> DAYS <b>MIN.</b>		IF UNDER 24 HRS HOURS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Keswick</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1701 St. Paul St.</b>			
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>J.</b> LAST <b>Turner</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Emily</b> MIDDLE <b>Griffith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-10-1580B</b>		17. INFORMANT ADDRESS <b>Records: Keswick 700 W. 40th St. 21211</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic CVD</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b) DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Fracture of left hip, 12/9!</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> 19 <b>79</b> to <b>1/6</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/6</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Harold P. Biehl MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-6-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold P. Biehl MD</b>						22e. ADDRESS <b>Keswick 700 W. 40th St. Balto, Md. 21211</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ambrose Inc. 1328 Sulphur Sp. Rd. 21227</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian A. Bandy</b>			

00000-25



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00991

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SCOTT T. S. HUBBARD</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>79</b>			2b. HOUR <b>12 28</b> M		
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>22</b> YEAR <b>51</b>		6 AGE (IN YEARS, LAST BIRTHDAY) <b>27</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA, Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD		
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Residential</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Mo</b>		13b. CITY OR TOWN <b>Balto</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1505 Cantwell Rd</b>		
14. FATHER'S NAME FIRST <b>Irwin</b> MIDDLE <b>Hubbard</b> LAST <b>Hubbard</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Antene</b> MIDDLE <b>Welkover</b> LAST <b>Welkover</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-52-9505</b>		17. INFORMANT ADDRESS <b>Rd.</b> <b>Mrs. Diane M. Hubbard, 1505 Cantwell</b>				
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral bleed</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disseminated Intravascular Coagulation</b> <b>10d</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>AML - relapse</b> <b>30d</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>November 19 77</b> to <b>1/1 79</b> , that (I) (we) last saw the deceased alive on <b>1/1 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Richard C. Stephenson</b> MD				22c. DATE SIGNED <b>1/1/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD C STEPHENSON</b>		
22e. ADDRESS <b>BCRC, Univ. Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3 JAN 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monticello Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Charlottesville</b> COUNTY <b>Va.</b> STATE		
24. FUNERAL DIRECTOR (NAME) <b>J. E. Lowell Lemmon</b> ADDRESS <b>Padonia &amp; York Roads</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10000-07

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00992

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) AUGUST C. HUBER			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1979			2b. HOUR P 3:28 M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner- Crown Refrigeration		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 5412 Catalpha Road			14. FATHER'S NAME FIRST MIDDLE LAST Henry Huber						
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						
16b. SOCIAL SECURITY NO. 213-09-8930			17. INFORMANT ADDRESS Mrs. Florence M. Huber 5412 Catalpha Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete heart block</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anterior MI.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>possible sepsis from pneumonia or UTI</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 28, 1978</u> to <u>Jan 13, 1979</u> , that (I) (we) last saw the deceased alive on <u>Jan 13, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>N. J. Belitros</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. J. Belitros			22e. ADDRESS Broadway & Orleans Balt Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-17-1979		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.						25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE <u>Fitzroy Helms</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-00993

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Walter</i>			2a. DATE OF DEATH MONTH <i>1</i> DAY <i>7</i> YEAR <i>79</i>			2b. HOUR <i>10:15</i> AM				
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH <i>1</i> DAY <i>13</i> YEAR <i>1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS		7. IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Balto</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Charles General</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i></i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <i>Willie</i> MIDDLE <i></i> LAST <i>Hughes</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Lucy</i> MIDDLE <i></i> LAST <i>Hughes</i>			16. STREET ADDRESS <i>1616 Thomas Avenue</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>228-05-5814</i>			17. INFORMANT ADDRESS <i>Sarah Hughes 1616 Thomas Avenue</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute pulmonary embolism</i> <i>4293</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <i>saddled heart</i> (c) <i>cardiomegaly</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <i></i> A.M. <i></i> MONTH <i></i> DAY <i></i> YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i></i> CITY OR TOWN <i></i> COUNTY <i></i> STATE <i></i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>11/21</i> , 19 <i>79</i> , to <i>11/27</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/27</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>H. Al-Midani M.D.</i> DEGREE <i></i>						22c. DATE SIGNED <i>1-7-79</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. Al-Midani M.D.</i>		
22e. ADDRESS <i>North Charles General Hosp</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1/11/79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Md. Nat. Mem. Park</i>			23d. LOCATION CITY OR TOWN <i>Laurel</i> COUNTY <i>Maryland</i> STATE <i></i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 East North Ave.</i> ADDRESS <i></i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 9 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

13-00003

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

41. [Illegible]

42. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-00994 REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST		2c. DATE OF DEATH		2d. HOUR		
Humphries - Baby Girl							1 25 '79		3:05pm		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
Female		White		1 MONTH 24 DAY '79				YRS. MONTHS DAYS		1 5	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore City, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Baltimore		Baltimore City Hospital									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14 FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
				Susan Humphries							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7703 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Hemorrhage										2 hrs	
Conditions, if any, which gave rise to immediate cause, or stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity										10 hrs	
										34 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 1/24 1979 to 1/25 1979 that (I) (we) lost saw the deceased alive on 1/25 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED					
Ethelyn Wang Jabs		MD.				1/25/79					
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
Ethelyn Wang Jabs				Baltimore City Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Baltimore City Hospital				FEB 1 1979				Ethelyn Wang Jabs			

BP



12-0000-02

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-00995			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Leo Hunt												2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR 1 3 1979		2b. HOUR M 9:48 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 15, 1922		6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 19 79		2d. HOUR P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3623 Brehms Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Parts Clerk				12b. KIND OF BUSINESS Chesapeake Cadillac			
13a. STATE Maryland				13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3623 Brehms Lane 21213					
14. FATHER'S NAME FIRST MIDDLE LAST Clement M.J. Hunt						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Schiminger									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W.II 213-18-6341		17. INFORMANT ADDRESS Marie Eva Hunt (wife) same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1/4/79							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/8/79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				ADDRESS 3331 Brhems Lane Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR JAN 5 1979		25b. REGISTRAR'S SIGNATURE					

53-000002

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-00996  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Addie						HUNTER		January 9 1979										7:00A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		Negro		8 4 1920		58		MONTHS		DAYS		HOURS		MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
South Carolina		U. S. A.				Baltimore City													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Maryland General Hospital																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2700 Auchentoroly Terrace									
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME																	
Allen		Lula																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS													
		096-24-8138		Darretta Watkins		536 Winston Avenue													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I. DEATH WAS CAUSED BY:		48 hours																	
IMMEDIATE CAUSE (a) <u>Bleeding Esophageal Varices</u>																			
5715																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b) <u>Cirrhosis</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION															
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE									
22. I certify that <del>XX</del> (this hospital) attended the deceased from <u>January 8</u> , 19 <u>79</u> , to <u>January 9</u> , 19 <u>79</u> , that <del>XX</del> (we) last saw the deceased alive on <u>January 9</u> , 19 <u>79</u> , and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>XX</del> (we) (did) (do not) view the body after death.																			
22a. SIGNATURE		DEGREE		22c. DATE SIGNED															
<u>S. Talaie</u>		M.D.		1-9-79															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Saied Talaie, M.D.		c/o Maryland General Hospital																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE									
Burial		1/13/79		King Memorial Park		Baltimore Co		Maryland											
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
NAME		ADDRESS																	
Wm. C. March F/H		1101 East North Ave.																	

12-00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-00997 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY C. ILGENFRITZ				MONTH DAY YEAR 1 / 4 / 79		2b. HOUR 3.55P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 26 10		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL OF MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CASPAR PREDIGER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRIEDERVICKA TRENTLE		13e. STREET ADDRESS 2674 DULANY STREET, 21223			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-62-9300		17. INFORMANT ADDRESS HOWARD A. ILGENFRITZ, 911 GROVEHILL ROAD 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe mitral stenosis with competent heart failure DUE TO, OR AS A CONSEQUENCE OF (c) failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/4 19 79, to 1/4 19 79, that (I) (we) last saw the deceased alive on 1/4 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sujeta Sapsiri				DEGREE MD		22c. DATE SIGNED 1-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUJETA SAPSIRI, M.D.				22e. ADDRESS Lutheran Hospital of Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-08-79		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR JAN 5 1979		25b. REGISTRAR'S SIGNATURE Lillian McCreedy	

78-00887

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-88 BY SP-6 BJS/STP

UNITED STATES DEPARTMENT OF JUSTICE

...

INVESTIGATION OF THE ACTS OF VIOLENCE

OF THE FEDERAL BUREAU OF INVESTIGATION

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UNITED STATES DEPARTMENT OF JUSTICE

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UNITED STATES DEPARTMENT OF JUSTICE

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100-443887-100



UNITED STATES DEPARTMENT OF JUSTICE

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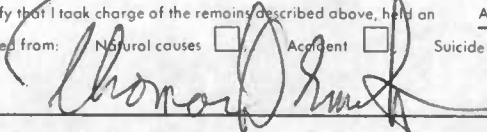
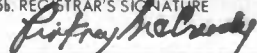
UNITED STATES DEPARTMENT OF JUSTICE



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**MEDICAL CERTIFICATION**

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				79-00998	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Dwight		Ingram					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2a. DATE KNOWN OF DEATH	8. ESTIMATED MONTH DAY YEAR	9. HOUR
Male	Black	January 10, 1950	28			1 9 19 79	1:05 PM
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore, Md.		U.S.A.				Baltimore City, Md.	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY	
Baltimore City		in front of 3512 Springdale Ave.		Construction-Worker			
18a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18b. STATE		19a. CITY OR TOWN		19b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.				Baltimore		5569 Kennison Ave.	
20. FATHER'S NAME FIRST MIDDLE LAST		21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		22. INFORMANT		23. ADDRESS	
Reginald Ingram		Carria Rheneheart (Rhinehart)		Carria Ingram		5569 Kennison Ave. 21215	
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		25. SOCIAL SECURITY NO.		26. INFORMATION		27. ADDRESS	
-----0-----				Carria Ingram		5569 Kennison Ave. 21215	
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of head</u> 7654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED?				32. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		33b. TIME OF INJURY HOUR MONTH DAY YEAR		33c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		12:45 PM 1 9 19 79		subject shot while operating motor vehicle			
34. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		35. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		36. LOCATION STREET CITY OR TOWN COUNTY STATE			
		street		3500 Blk. Springdale Ave. Balto City, Md			
37. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
38. ACTUAL SIGNATURE		39. EXAMINER'S NAME (TYPE OR PRINT)		40. ADDRESS		41. DATE SIGNED	
		Thomas D. Smith, M.D.		111 Penn St. Balto., Md.		1/10/79	
42. BURIAL, CREMATION, REMOVAL (SPECIFY)		43. DATE		44. NAME OF CEMETERY OR CREMATORY		45. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/12/79		Arbutus Mem. Park		Baltimore, Maryland	
46. FUNERAL DIRECTOR NAME ADDRESS				47. DATE REC'D. BY REGISTRAR		48. REGISTRAR'S SIGNATURE	
K. Law Funeral Home 4611 Park Heights Ave.				JAN 17 1979			

79-00998

January 1, 1950

x

Attorney, U.S.A.

Construction - order

2220 Madison Ave.

Attorney

I.C.

Garrie, the agent (in short)

Garfield Laram

Garrie Laram, 1212 Madison Ave., N.Y.

Attorney, I. L. Laram

Attorney, I. L. Laram

1/1/50

Garrie

Garrie Laram, 1212 Madison Ave., N.Y.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

1- STATE REGISTRAR										79-00999									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH									
Bettye Ireland										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 24 1979									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		White		OCT. 22, 1914		64 YRS.						1 24 1979		10:30A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND				USA								Baltimore City, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF POSTAL HOSPITAL HOME, OR INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore City				Seaton Hill Manor				HOUSEWIFE				AT HOME							
13a. STATE										13b. CITY OR TOWN									
MARYLAND										BALTO. OWINGS MILLS									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
ISAAC BRENNER										FRIEDA DESSER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.									
NO										NO									
17. INFORMANT										17. ADDRESS									
MRS. RUTH CHENOW										6-G TAHOE CIR., OWINGS MILLS, MD 21117									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY: Drowning																			
IMMEDIATE CAUSE (a)																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?									
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR 1/24/79				drowned in bathtub											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				nursing home				501 W. Franklin St. Baltimore Maryland											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY)						DATE SIGNED									
Thoma s D. Smith, M.D.				M.D. Deputy Chief						1/24/79									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
				111 Penn St. Balto., MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
BURIAL				JAN. 26, 1979		WORKMEN CIRCLE				BALTIMORE MARYLAND									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR									
SOL LEVINSON & BROS., INC.										JAN 30 1979									
NAME ADDRESS										25b. REGISTRAR'S SIGNATURE									
6010 REISTERSTOWN RD., BALTO., MD 21215																			

12-00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01000			
1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Agnes</b> MIDDLE <b>M.</b> LAST <b>Isebrook</b> <b>Agnes M. Isebrook</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-23-79</b>				2b. HOUR <b>11 29 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 4, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7001 Dunmanway,</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Not Known</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret</b>				ADDRESS <b>438 S. Drew St.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>MA881386 RR</b>		17. INFORMANT <b>Mrs. Velma M. Andrews,</b>				ADDRESS <b>Balto. Md. 21224</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest.</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>mesenteric thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>sepsis + hemorrhage (GI)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>1/23, 1979</b> to <b>1/23, 1979</b> , that (I) <del>was</del> last saw the deceased alive on <b>1/23, 1979</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> <del>not</del> view the body after death.											
22b. SIGNATURE <b>Samuel J. Abrams</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/23/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Samuel J. Abrams</b>				22e. ADDRESS <b>2435 W. Belvedere Ave</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>				ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McCreedy</b>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01001

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Hebrew Jackson			2a DATE OF DEATH MONTH DAY YEAR 1 28 79			2b HOUR M			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 8 14 07		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1701 N. Eutaw Place				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1701 N. Eutaw Pl.	
14 FATHER'S NAME FIRST MIDDLE LAST Unkn				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO. 217-01-0822		17 INFORMANT ADDRESS Inez Cornelius 49 Ordnance Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 2839 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hemolytic Anemia</u> (c) <u>Periphenal Vascular Disease, Coronary Artery Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 8</u> , 19 <u>79</u> , to <u>JAN 1</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>JAN 1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) saw the body after death.									
22b. SIGNATURE <u>Rona H. Frank</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANNA H. FRANK				22e. ADDRESS JOHNS HOPKINS University					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.		
24 FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.			25a. DATE RECORDED BY REGISTRAR JAN 30 1979		
						25b. REGISTRAR'S SIGNATURE <u>Rona H. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10010-01

10010-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01002

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR		
Howard			L. Jackson			MONTH DAY YEAR 1 21 19 79			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	Black	MONTH DAY YEAR 6 9 1909	69 YRS.	MONTHS DAYS	HOURS MIN	1 23 19 79			4:50P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			U. S. A.						Baltimore City, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City			1312 E. Eager Street								
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13 East Eager Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Freeman			Jackson			Martha Doles			218-05-4322		
17. INFORMANT			ADDRESS			17. INFORMANT			ADDRESS		
No			Ellen Jackson			1646 N. Appleton St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			TITLE (SPECIFY)						DATE SIGNED		
			M.D. Deputy Chief						1/24/79		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Thomas D. Smith, M.D.			111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			2/6/1979			Baltimore Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Wm. C. March F/H			1101 East North Ave.			FEB 6 1979					

BP

52-01005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01003 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Lloyd Jackson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>January 26, 1979</i>			
3. SEX <i>male</i>				7b. HOUR <i>8/10PM</i>			
4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9/27/94</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF MONTHLY FACILITY, GIVE STREET ADDRESS) <i>2319 Washington Blvd.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clergy</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Severn</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jefferson Jackson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virginia Finch</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>214-14-7117</i>		17. INFORMANT ADDRESS <i>Roland Jackson San Diego, California</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>410- KOS: A M I</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>the doctor</del> attended the deceased from <i>4/1/74</i> , 19____, to <i>9/76</i> , 19____, that (I) (we) lost saw the deceased alive on <i>10/76</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/29/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Manuel Sanchez</i>				22e. ADDRESS <i>1424 Sulphur Spring Road</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/30/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie A.A. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Hardesty Funeral Home</i> ADDRESS <i>12 Ridgely Avenue</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 31 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

10010-02

1-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01004	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL REGINA JACKSON		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 31, 1979	
3 SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 25 1906	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7c. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTEBELLO CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST NATHANIEL KESS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST QUEENIE JOHNSON		17. INFORMANT ADDRESS Leila Roberts 1004 Camerson Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-24-5080		17. INFORMANT ADDRESS Leila Roberts 1004 Camerson Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAT CELL CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he (this hospital) attended the deceased from 1/11, 1979, to 1/31, 1979, that (he (we) lost saw the deceased alive on 1/31, 1979, and that in (my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Alfred Gakenheimer MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. ALFRED GAKENHEIMER		22e. ADDRESS MONTEBELLO CENTER BALTIMORE MD. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/1979		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 East North Ave.		25a. DATE REC'D. BY REGISTRAR FEB 2 1979	
25b. REGISTRAR'S SIGNATURE R. H. McCreedy					

BP

10010-01





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					79-01005					
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Baby Boy Jacobs.					2a. DATE OF DEATH MONTH DAY YEAR 1 9 '79				2b. HOUR 9:55 AM	
3 SEX Male		4 RACE Black.		5. DATE OF BIRTH MONTH DAY YEAR 12 15 78		6 AGE (IN YEARS LAST BIRTHDAY) 25 days		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. - 25		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland.		7b CITIZEN OF WHAT COUNTRY? USA.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -		12b. KIND OF BUSINESS OR INDUSTRY -		
13a STATE Md.					13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS -	
14 FATHER'S NAME FIRST MIDDLE LAST not given					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Jacobs.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -					16b SOCIAL SECURITY NO. -		17 INFORMANT ADDRESS -			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 7757 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metabolic Acidosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins 1 hours 3 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Prematurity</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. Hylin Wang Jals						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/9/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Hylin Wang Jals						22e. ADDRESS -				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME -					ADDRESS -		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 18 1979 [Signature]			

BP

1/1/11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMM - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01006 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Helen G Jacobs</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>-1</b> YEAR <b>19 79</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>8</b> YEAR <b>01</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD <b>1 - 1 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>511 West Northern Parkway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Michigan</b>				13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Ecorse</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4488 Monroe St.</b>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b></b> LAST <b>McDonald</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b></b> LAST <b>Ball</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>370-24-0144</b>		17. INFORMANT ADDRESS <b>Ecorse, Michigan</b> <b>Ballheimer Funeral Home</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Hormez R. Guard</b>						TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>1/2/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>						ADDRESS <b>111 Penn Street, Balto, MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>1/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Michigan Memorial</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flatrock, Michigan</b>	
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry W. Jenkins</b>			

BP

20010-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

BP

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01007 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ROSE JACOBS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01 08 79</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 18 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOTHING SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERICAL WORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CATS PAW CO.</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS JACOBS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA KRAUSS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO <b>215-01-2764A</b>		17. INFORMANT ADDRESS <b>LEWIS JACOBS 6948 BROOKMILL RD., APT. 2A</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TO BRAIN TUMOR w/ METS</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2396 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS ABOVE</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIO PUL ARREST</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 10 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/07</b> 19 <b>78</b> , to <b>1/8</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/07</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Raymond J. Altieri MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND J ALTIERI</b>				22e. ADDRESS <b>SINAI HOSP</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>JAN. 9, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW ORTHODOX MEM. SOC.</b>	
23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>D</b>				24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. INC.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25. DATE REC'D BY REGISTRAR <b>JAN 12 1979</b>			

MEDICAL CERTIFICATION

70010-07

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **79-01008**

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**LEROY JAMES**

2a. DATE OF DEATH MONTH DAY YEAR  
**01 20 79**

2b. HOUR  
**12:21P<sub>M</sub>**

3. SEX  
**Male**

4. RACE  
**Negro**

5. DATE OF BIRTH MONTH DAY YEAR  
**11 29 1905**

6. AGE (IN YEARS (LAST BIRTHDAY))  
**73** YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Virginia**

7b. CITIZEN OF WHAT COUNTRY?  
**U. S. A.**

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**Baltimore** City MD.

10. CITY OR TOWN OF DEATH  
**Baltimore**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Church Home and Hospital**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
**Maryland**

13b. COUNTY  
**Baltimore**

13c. CITY OR TOWN  
**Baltimore**

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS  
**283 Ballou Court**

14. FATHER'S NAME FIRST MIDDLE LAST  
**Nathaniel James**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Mary Jackson**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
**No**

16b. SOCIAL SECURITY NO.  
**212-16-3575**

17. INFORMANT ADDRESS  
**Mary James 283 Ballou Court**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Cardiorespiratory Arrest**

0932

DOE TO, OR AS A CONSEQUENCE OF **Luetic Aortic Regurgitation**  
(b) **with Congestive Heart Failure & atrial fibrillation**

DOE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

(1) **Chronic Renal Failure** (2) **Diverticulosis with chronic bleeding**

19a. DATE OF OPERATION  
**XXXXXXXXXXXX**

19b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  
**(3) Anemia secondary to 1&2**

21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21e. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (this hospital) attended the deceased from **1-18** 19 **79**, to **(New) 1/20** 19 **79**, that (we) lost  
saw the deceased alive on **1-18** 19 **79**, and that in (our) opinion death occurred on the date and hour and from the causes stated  
above, (we) (did) (not) view the body after death.

22b. SIGNATURE **C. S. CHEN** DEGREE  ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**C. S. CHEN**

22e. ADDRESS  
**Church Hospital**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**1/24/1979**

23c. NAME OF CEMETERY OR CREMATORY  
**King Memorial Park**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**Baltimore Co., Maryland**

24. FUNERAL DIRECTOR NAME ADDRESS  
**Wm. C. March F/H 1101 East North Avenue**

25a. DATE REC'D. BY REGISTRAR  
**JAN 22 1979**

25b. REGISTRAR'S SIGNATURE  
**L. J. McCreedy**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



80010-25



20% COFFEE

Handwritten text at the bottom left, possibly a signature or date.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01009

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
SHANEY Danielle		JAMISON			JAN 31 29					1:30 A <sub>M</sub>		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE	BLACK		AUG 1 1978		YRS 5 31		MONTHS 5 31		DAYS 5 31			
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore		USA				BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE CITY		SINAI Hospital				N/A						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
13a. STATE					13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5531 Radeke AVE					
13a. COUNTY					13c. CITY OR TOWN							
MARYLAND					BALTIMORE CITY							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
Larry J. Thomas					STACEY JAMISON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					none		Mr. Larry J. Thomas-5203 Cuthbert Ave					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPTIC SHOCK

7855

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1979, to Jan 31, 1979, that (I) (we) last saw the deceased alive on Jan 31, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE James A. Romberger Jr MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/31/78	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Romberger Jr MD		22e. ADDRESS SINAI HOSPITAL BELVEDERE & GREENSPRING BLVD NO 21215					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2-3-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave.				25a. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE Petry Melvody	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19-01009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01010 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1 5 79			
1. DECEASED NAME FIRST MIDDLE LAST Sophima Catherine Jarrell				2b. HOUR 8:30 A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 22 04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployd		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 5260 Patrick Henry Dr. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST SAMSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <del>UNKNOWN</del> NARTHA (Dec) Hawks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213 74 4303		17. INFORMANT ADDRESS Mr. David B. Mc Millan 222 Andover Road Linthicum, Md. 21090			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.							
IMMEDIATE CAUSE (a) Cardio-respiratory arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-2-78, 19 78, to 1-15-79, 19 79, that (I) (we) last saw the deceased alive on 1-15-79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Miguel Fleischman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miguel Fleischman				22e. ADDRESS South Balto. General			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY Baltimore Anne Arundel Md.	
24. FUNERAL DIRECTOR Mc Cully Funeral Home of Brooklyn 237 E. Patapsco Avenue Balto., Md. 21225				25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

19-01010

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1974 4 13

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01011  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT J. JASAITIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 31, 1979</b>			2b. HOUR <b>8:00P</b> M				
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 29 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2+ YRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>311 South Woodyear St. 21223</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Metal Smelt.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>311 S Woodyear St 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Jasaitis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Paplauskas</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW-11</b>		17. INFORMANT ADDRESS <b>Anna Colvin/7914F Vintage Cir/ Glen Burnie 21061</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden death - Massive</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>History of MI and ischemic heart disease</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Jan 31, 1979</b> , that (I) (we) lost saw the deceased alive on <b>more than 1 year ago</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Stanley Anklidas</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1.31.79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY ANKLIDAS</b>				22e. ADDRESS <b>1101 Maiden Choice La (Balt) MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>02/03/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walters Funeral Home/Pratt &amp; Stricker Streets 21223</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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11010-05

UNITED STATES GOVERNMENT  
OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01012

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Rose A. JECNY</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>4</b> YEAR <b>79</b>		2b. HOUR <b>5</b> AM
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>12</b> YEAR <b>1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Czech.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Gardens Nur. Hm.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. STREET ADDRESS <b>4700 Harford Road</b>		
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>-</b> LAST <b>Jecny</b>		15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>-</b> LAST <b>-</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-14-4885</b>		17. INFORMANT ADDRESS <b>Geo. Thomsen (Atty) 1723 Munsey Bldg. 21202</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> (c) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>Mar. 20</b> 19 <b>72</b> , to <b>Jan. 4</b> 19 <b>79</b> , that (2) we lost saw the deceased alive on <b>Dec. 26</b> 19 <b>70</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)					
22b. SIGNATURE <b>Ray M. Zimmerman MD</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/4/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ray M. Zimmerman MD</b>		22e. ADDRESS <b>3202 Harford Rd, Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR <b>Schamunek Funeral Home, Inc.</b>		3331 Brehms Lane Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Barney</b>	

18-01015

Released - on approval by Dr. Ripon per Mr. Gregory  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01013 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOE EMMA JEFFERSON			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29 1979		2b. HOUR 3:50A <sup>AM</sup>
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 11 27 1905		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. CITY OR TOWN OF DEATH Baltimore			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5514 Leith Road			
14. FATHER'S NAME FIRST MIDDLE LAST Will Holmes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julie Holmes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 215-24-8403		17. INFORMANT ADDRESS Joe R. Jefferson 2206 Eutaw Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Death</u> 4321 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subdural hematoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 1/27/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural hematoma		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/27, 19 79, to 1/29, 19 79, that (I) (we) last saw the deceased alive on 1/29, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. S. Faruqi		DEGREE MD		22c. DATE SIGNED 1/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. S. Faruqi		22e. ADDRESS 601 N Broadway 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Ave.			
25a. DATE REC'D. BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCready			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01014 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
John		W.		JEFFREY				JANUARY 24, 1979		10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Dec. 13, 1901		78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Scranton, Pa.		USA				Baltimore City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Long Green Nursing Home						Cabinet Maker		Lucas Bros.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Baltimore				3021 Crestmont Ave., 21211			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles L. Jeffrey				Lizzy Woodhouse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				174-03-7245-A		Helen L. McAminch				Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4340 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized A.S.</u>										1 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Muscular dystrophy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17/52</u> to <u>1/24</u> 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>1/16</u> 19 <u>79</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Norman R. Freeman</u>								<u>1/25/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Dr. Norman Freeman, M.D.				11 W. 29th Street Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		1-29-79		Woodlawn		Baltimore Co., Maryland					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.				JAN 26 1979				<u>Henry W. Jenkins</u>			
4905 York Road Balto., Md. 21212											

10-01014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01015 REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH				2b HOUR	
		Cornelius Jeffries				January 28, 1979				7:35 <sup>a</sup> M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Negro		MONTH DAY YEAR 10 16 1884		94 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U. S. A.				Baltimore City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1620 East Chase Street			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST UNKN				FIRST MIDDLE LAST UNKN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No				215-03-8011		Wash., D. C. Malachi Jett 5907 Blair Road					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial Infarction											
486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE					
22 I certify that (this hospital) attended the deceased from January 15, 1979, to January 28, 1979, that (we) lost saw the deceased give on January 28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED	
Larry Stein M.D.				MD						1/28/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
				C/O Maryland General Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		2/2/1979		Arbutus Mem. Park		Arbutus, Maryland					
24 FUNERAL DIRECTOR NAME ADDRESS						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Wm. C. March F/H 1101 East North Ave						JAN 31 1979		L. J. McCreedy			



13-01012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01016 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Julia Jenkins</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>JANUARY 27, 1979</i>				2b. HOUR <i>12:30</i> M	
3. SEX <i>Female</i>		4. RACE <i>Col.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 12, 1931</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>47</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTO.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John P. Deaton Medical Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>BALTO</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harrey C. Thompson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>L.A. Warren</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES, GIVE WAR OR DATES <i>NO</i>			
16a. SOCIAL SECURITY NO. <i>216-24-0683</i>				17. INFORMANT ADDRESS <i>Mrs. Catherine Spencer 1100 Bolton St APT 317</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Carcinoma, the breast</i> <i>1749</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b): DUE TO, OR AS A CONSEQUENCE OF (c):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-23</i> 19 <i>79</i> , to <i>1-27</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>1-27-79</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Marsita Brown</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/27/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARSITA Brown</i>				22e. ADDRESS <i>611 S. Charles St.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/1/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westport</i>		23e. REGISTRAR'S SIGNATURE <i>Joseph L. Russ</i>	
24. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i>				ADDRESS <i>2222 W. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 5 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Joseph L. Russ</i>	

BP

19-01016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01017 REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME FIRST MIDDLE LAST OWEN E. JIGGETTS SR.			2a. DATE OF DEATH MONTH DAY YEAR 1-30-79		2b. HOUR 11:59 P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6-28-41	6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Fighter.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. STREET ADDRESS 5208 CRAIG AVENUE	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY JIGGETTS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina JACKSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-38-6127	17. INFORMANT ADDRESS Joanne Debra Jiggetts 5208 CRAIG AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination 20 to Cephylized Vene</u> 5712 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>79</u> , to <u>1/30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Warren M. Ross, MD</u>		DEGREE MD		22c. DATE SIGNED 1/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN M. ROSS, MD		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-3-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md					
24. FUNERAL DIRECTOR NAME W. E. FREEMAN		ADDRESS 6205 CHINQUAPIN PKWY		25a. DATE REC'D. BY REGISTRAR FEB 5 1979	
25b. REGISTRAR'S SIGNATURE <u>Henry H. Cusack</u>					

79-01017

DATE	TIME	PLACE
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2
1952	11:00	Male
MILWAUKEE CITY	N. 2. 4	1/2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01018

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MURIEL S JOHN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3 1979			2b. HOUR 8 36 P M		
3 SEX F		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT 9, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 66		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY AA		13c. CITY OR TOWN ANNAPOLIS		
14. FATHER'S NAME FIRST MIDDLE LAST HECTOR SMITH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE HUNTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 32 5727		17. INFORMANT ADDRESS DAVID JOHN 9413 FAIRVIEW AVE. LAUREL, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4410 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Overdosing, sepsis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Dissecting aortic aneurysm: reparatory insufficiency</u>								
19a. DATE OF OPERATION 12/21/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting aortic Aneurysm		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>79</u> , to <u>7/3</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>7/3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE CRAIG DUFRESNE MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/3/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRAIG DUFRESNE MD				22e. ADDRESS JH/H				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JAN 5, 1979		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE, MARYLAND		
24. FUNERAL DIRECTOR NAME DONALDSON FUNERAL HOME, BALTIMORE, MD				25a. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE R. J. McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

81040-25

RYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01019 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Valene BB Johnson A</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1-13-79</b>			2b. HOUR MIN <b>6 41 AM</b>		
3. SEX <b>male</b>		4. RACE <b>Wek</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 10 79</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2 days</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MD</b>					
10. CITY OR TOWN OF DEATH <b>Boet.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BCH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>Balt</b>		13c. CITY OR TOWN <b>Boet</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4940 Eastern ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>769-</b> IMMEDIATE CAUSE (a) <b>Cerebral and Respiratory Embolism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Respiratory distress syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypotension, Bradycardia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Arteriosclerosis</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>79</b> , to <b>1-13</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C Ye Aetling MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>				

13-01013

13-01013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01020 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Baby Boy Johnson				2a. DATE OF DEATH MONTH DAY YEAR 1 12 79				2b. HOUR 6:41 AM
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 10 79		6. AGE (IN YEARS LAST BIRTHDAY) 1 1/2 days old		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1 1/2
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS
14. FATHER'S NAME FIRST MIDDLE LAST Timothy - Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Valerie - Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 769- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metabolic Acidosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hyaline Membrane Disease</u>								
19a. DATE OF OPERATION 1 9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/10 19 79 to 1/12 19 79, that (I) (we) last saw the deceased alive on 1/12 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Ethelin Wang Jals				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/12/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ethelin Wang Jals				22e. ADDRESS Baltimore City Hospitals				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY per Baltimore City		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]

BP

12-01050

12-01050

12-01050

12-01050

12-01050

12-01050

12-01050

12-01050

12-01050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **79-01021**

1. DECEASED NAME (TYPE OR PRINT) <b>Albert Johnson</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>26</b> YEAR <b>79</b>			2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>4</b> YEAR <b>78</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>100</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1700 Eutaw Place</b>	
14. FATHER'S NAME FIRST <b>Unkn</b> MIDDLE <b></b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Unkn</b> MIDDLE <b></b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-01-5076</b>		17. INFORMANT ADDRESS <b>Dorothy Wilson 2332 Calverton Hgts</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S. Cardio Vascular Disease Many Years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Multiple Decubets, Renal Failure Chronic</b>									
19a. DATE OF OPERATION <b>1/1/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 79</b> to <b>Jan 19 79</b> , that (I) (we) lost saw the deceased alive on <b>1/1/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David M Posner</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David M Posner</b>				22e. ADDRESS <b>18 E Eager ST</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/31/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McElroy</b>	

BP

10010-01

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01022  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carl Johnson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 1, 1979</b>			2b. HOUR <b>5:15 p.m.</b>				
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 20 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1718 Saint Paul Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ivy King</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>250-24-8296 Robin McCullough 1718 St. Paul Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure secondary to lung cancer</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Brain metastasis</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 1</b> 19 <b>79</b> to <b>January 1</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 1</b> 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE <b>Adrian E. Long</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/1/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Adrian Long, M.D.</b>						22e. ADDRESS <b>827 Linden Ave. Baltimore MD 21201</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/8/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>		



SS010-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01023 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
INEZ JOHNSON				1 17 1979 12:00 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
F		Black		7 4 1917		61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
VA.		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		South Baltimore General					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland						Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
William Craig				Mary Virginia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				214-26-4491		Phillip Howard 212½ Evans Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4331 LEFT CEREBRAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) LEFT CAROTID ARTERY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS, HYPERTENSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-16-1979, to 1-17-1979, that (I) (we) last saw the deceased alive on 1-17-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. Pathmanathan M.D.				DEGREE M.D.		22c. DATE SIGNED 1/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sivakolunthunathan Pathmanathan				22e. ADDRESS 3001 S. Hanover St. Baltimore, M.D.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/22/79		Arbutus Mem. park		Arbutus, Maryland	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				JAN 19 1979		Ritony McCreedy	

10-01053



POST OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-01024 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR MIN	
Mary		O.		Johnson				January 15, 1979		11:35P	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		Negro		July 4- 1906		72 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
Maryland		USA									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital						Domestic			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS			
Maryland		Calvert		Lusby				Box 142 A			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William T. Johnson				Druisalla Johnson							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
no				215-64-6214		Elizabeth Haley 24-45 Gilmore St. N.Y.					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> (c) <u>Due to, or as a consequence of</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Congestive Heart Failure</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 15</u> , 19 <u>79</u> , to <u>January 15</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 15</u> , 19 <u>79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b SIGNATURE <u>Charles Graham M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 1-16-79			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles Graham, M.D.				22e ADDRESS c/o Maryland General Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		Jan.-19-79		St. Johns Chr. Cem.		Lusby Calvert Md.					
24 FUNERAL DIRECTOR NAME Spencer E. Sewell						ADDRESS Prince Frederick, Md.		25a DATE REC'D BY REGISTRAR JAN 22 1979			

AS010-85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VR A 15 (4))

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01025  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Moses				Johnson, Jr.	1 7 79					12:10 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Black	MONTH DAY YEAR 5 16 17		61		MONTHS DAYS		HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.			Baltimore City MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	Lutheran Hospital				Unemployed					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1501 N. Dukeland St.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
FIRST MIDDLE LAST Moses		FIRST MIDDLE LAST CAROLINE		16a. NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		249-14-0295		Joshua Johnson 3704 Edmondson Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 436- DUE TO, OR AS A CONSEQUENCE OF (b) Post - CPR DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETIC GANGRENE (P) FOOT										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
12/14/78		GANGLIOMA			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (this hospital) attended the deceased from 12/2, 19 78, to 1/7, 19 79, that (we) last saw the deceased alive on 1/7, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
J.P.G. VALLE JR		MD				1/7/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
J.P.G. VALLE JR		LUTHERAN HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		1/12/79		Westview Mem. Park		Catonsville, Maryland		COUNTY		STATE
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wm. C. March F/H 1101 East North Ave.				JAN 5 1979		[Signature]				

BP

38-01052

X





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. **79-01026**

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTI-MATED		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR	
Nathaniel Johnson		1 10 1979		11:58 a M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	Black	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS DAYS	HOURS MIN
		7 7 1909	69 YRS.		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore City		111 W. Centre St.		Contractor	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.				Balto.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Rev. Alfred Johnson		Charlesanna Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT		ADDRESS	
no		Mrs. Mattie Johnson		1008 Woodington Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>					
4292 } DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on <u>partial</u> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<i>Thomas D. Smith</i>		M.D. Deputy Chief		1/10/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Thomas D. Smith, M.D.		111 Penn St. Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/15/79		Arbutus Mem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JAMES A. MORTON & SONS		JAN 12 1979		<i>Patricia Hebrudy</i>	
ADDRESS					
1701 LAURENS ST.					

79-01028

7 7 1971

U.S.A.

NY

Contractor

1008 Woodington Ave.

Balto.

NY

Charlottesville Taylor

Rev. Alfred Johnson

Mrs. Mattie Johnson 1008 Woodington Ave.

NY

partially

partially

partially

partially

partially

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01027	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROLAND JOHNSON.					2a. DATE OF DEATH MONTH DAY YEAR 01 18 79			2b. HOUR 11.50 A.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 7 28 1924		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Richard Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Stanley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-20-3475		17. INFORMANT ADDRESS Alma Johnson 1803 East North Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASPIRATION. (c) MID BRAIN Cerebrovascular ACCIDENT DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hx OF OLD CVA, DM - INSULIN DEPENDENT, HBP. @ BKA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from 1-09 19 79, to 1-18 19 79, that (we) last saw the deceased alive on 1-18- 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE Dennis J. Chodnicki					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1-18-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS J. CHODNICKI, M.D.					22e. ADDRESS UNION MEMORIAL HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/22/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.					25a. DATE REC'D. BY REGISTRAR JAN 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

78-01057

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01028

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT W. JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 10<sup>th</sup> 79</b>		2b. HOUR <b>9:50 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 18 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mount Pleasant (Sinai)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Westley Davis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Davis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Juanita Collins 2118 E. Madison St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema, Respiratory Failure.</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA of the Lung with Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if this hospital) attended the deceased from <b>12-26-</b> 19 <b>78</b> , to <b>01-10</b> 19 <b>79</b> , that (we) last saw the deceased alive on <b>01-10-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>K. S. Chahal</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>01/10/79.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. S. CHAHAL</b>		22e. ADDRESS <b>SINAI HOSPITAL, BALTIMORE Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/13/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave</b>		ADDRESS <b>BALTIMORE Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>	
				25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01029	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY M. JONES					MONTH DAY YEAR 1 15 79					6-10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1896			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur L. Jones					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella M. Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 219-22-0210		17. INFORMANT ADDRESS Edward C. Jones Balto., Md. #21211				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart dis. &amp; arrhythmia.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACCIDENTS.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>intertrochanteric Fr. left hip.</u>											
19a. DATE OF OPERATION 1/13/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture left hip				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR (P.M.) 1 13 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Fell at home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 310 McMechen St. Bal. Md.							
22a. I certify that (1) (this hospital) attended the deceased from 1/13 to 1/15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Hu Chen-Sien				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HU CHEN-SIEN, M.D.				22e. ADDRESS UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/18/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-01030

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth CONSTANCE Jones</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1 19 79</i>		2b. HOUR <i>3:20 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 14 17</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>61 YRS.</i>	
10. CITY OR TOWN OF DEATH <i>BALTO</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>U MD</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. CITY</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tele. Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>C &amp; P Tel.</i>		13a. STREET ADDRESS <i>21236 4151 Glen Park Rd</i>	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN <i>Baltimore</i>		13d. STATE <i>MD</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Gaetano Anzalone</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Signarello Timmarello</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>219-03-4893</i>		17. INFORMANT ADDRESS <i>Leo G. Jones (husb.) same as 13</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary demise</i> 430- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>brain death</i> (c) <i>intracerebral hemorrhage &amp; aneurysm</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>hypertension</i>					
19a. DATE OF OPERATION <i>1/18/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>hemorrhage ruptured aneurysm</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/17</i> , 19 <i>79</i> , to <i>1/19</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>1/19</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>M. Carol</i>		DEGREE <i>U MD</i>		22c. DATE SIGNED <i>1/19/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARK CAROL</i>		22e. ADDRESS <i>U MD</i>		22f. DATE SIGNED <i>1/19/79</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Crypt</i>		23b. DATE <i>1/22/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>		24. FUNERAL DIRECTOR <i>Schamunek Funeral Home, Inc.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 23 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>		25c. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>		25d. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01031  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James EDWARD Jones			2a DATE OF DEATH MONTH DAY YEAR 1 21 79			2b HOUR 6:45 A.M.			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Nov. 23 16		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md				13b COUNTY Balto		13c CITY OR TOWN Balto		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST James Jones				15 MOTHER'S MAIDEN NAME MIDDLE LAST Fannie Willis					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 212-12-1944		17 INFORMANT ADDRESS MRS. JURLIN MITCHELL 2420 W. FRANKLIN ST.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>General Debilitation</u> (c) <u>Squamous Cell Carcinoma Lung</u> 9-10 months PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/18/79, 19, to 1/21/79, 19, that (I) (we) last saw the deceased alive on 1/21, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert L. Smith						DEGREE MD		22c. DATE SIGNED 1/21/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Smith						22e. ADDRESS University Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-24-79		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PL.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD		
24 FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY STS.						25a. DATE REC'D. BY REGISTRAR JAN 23 1979		25b. REGISTRAR'S SIGNATURE Ricky McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18010-01

AD 10-10-10



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01032  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Pierce Jones</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 79</b>		2b. HOUR <b>4:45 PM</b>
3. SEX <b>male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 14 1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>		
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>steel</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Jones</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Ford</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-07-5101</b>	17. INFORMANT ADDRESS <b>Mrs. Margaret Jones 715 Avondale</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypovolemic Shock</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>12-11-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Stomach</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-22</b> , 19 <b>79</b> , to <b>1-17</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1-17</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas H. Fleisher</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-17-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas H. Fleisher III</b>		22e. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1-22-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Carlton C. Douglass</b>		ADDRESS <b>1012 Penn. Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

53-01035

FOR OFFICIAL USE ONLY  
DO NOT WRITE IN THESE SPACES  
FBI - MEMPHIS





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be secured in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized copies. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01033 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) THOMAS C. JONES						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 42, 1979				2b. HOUR 8.45A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 23 34		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY DAIRY			
13a. STATE MD						13b. COUNTY		13c. CITY OR TOWN Bucks Port		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST milbwen JONES						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE COOK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 006-58-394		17. INFORMANT ADDRESS PO. BOX 153 KAREN JONES AMBERT MANS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 2040 DUE TO, OR AS A CONSEQUENCE OF: (b) Cardiopulmonary arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Acute lymphocytic leukemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Status post bone marrow transplantation											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/13 19 79, to 1/12 19 79, that (I) (we) last saw the deceased alive on 1/12 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.											
22b. SIGNATURE Scott H. Wood						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/12/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott H. Wood						22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 1-13-79		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW PK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR NAME JOHN M. WEBER						ADDRESS 401 S. CHESTER		25a. DATE REC'D. BY REGISTRAR JAN 18 1979		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

#17, per call w/F.H. 1- STATE REGISTRAR 1/10/79 kam												STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 79.01034 REG. NO. 11181881													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM P. JONES												2a. DATE OF DEATH MONTH DAY YEAR 1/5/79												2b. HOUR 6:15a.m.	
3. SEX Male				4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR 5/30/91				6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.													
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor N. H.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker				12b. KIND OF BUSINESS OR INDUSTRY Food Retail									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.												13b. COUNTY 21216		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2920 Brighton St.							
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Jones						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hendricks																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I 214-01-2590				17. INFORMANT M. Jones 2920 Brighton St.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Heart Failure</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 4 mos.																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Atrial Fibrillation - Flutter x 4 mos.</u>																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-30</u> , 19 <u>78</u> , to <u>1-4</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE Jaime M. Punzalan								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-5-79													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jaime M. Punzalan, M. D.								22e. ADDRESS 5508 Belair Rd., 21206																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 7, '79		23c. NAME OF CEMETERY OR CREMATORY Waugh Chapel				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.															
24. FUNERAL DIRECTOR NAME William E. Johnson								25a. DATE REC'D. BY REGISTRAR JAN 9 1979				25b. REGISTRAR'S SIGNATURE Dietrich McBratney													
ADDRESS 8521 Loch Raven Blvd.																									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M

(VR A 15 (4) 19/74)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01035

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		January 11 1979		6:38 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		CAUCASIAN		December 28 1901		77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				BALTIMORE City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SOUTH BALTIMORE GEN. HOSP.		Homemaker		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Maryland		Anne Arundel		Baltimore		304 Seward Avenue 21225	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Frank		Virginia		No		216-12-5350	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
William A. Murphy		410- Cerebral infarction Cerebral infarction myocardial infarction Hypertensive intracerebral hemorrhage		Old CVA, Hypertension		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from January 5, 1979, to January 11, 1979, that (we) last saw the deceased alive on January 11, 1979, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		Annette G. Galliano		Jan 11, 1979		Annette G. Galliano	
22e. ADDRESS		22f. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
South Baltimore General Hospital				Burial		Jan. 13, 1979	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Cedar Hill Cemetery		Baltimore, Maryland		237 East Patapsco Avenue		Jan 16 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		Mcully Funeral Home of Brooklyn Balto., Md. 21225		D. J. Kelly	

28010-07



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01036

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Patrick Richard Joyce			2a. DATE OF DEATH MONTH DAY YEAR 1 4 79			2b. HOUR 7:50A <sub>M</sub>			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 8, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7 UNDER 1 YEAR MONTHS DAYS 7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCRANTON, PA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hos pital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD.		13b COUNTY ---		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 625 S. DEAN ST. # 21223.	
14 FATHER'S NAME FIRST MIDDLE LAST RICHARD JOYCE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE MARLEY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17 INFORMANT ADDRESS A. HELEN JOYCE : 625 S. DEAN ST. BALTO., 21224, MD.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SEVERE Lactic Acidosis + Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) SEPSIS DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCVD + Atrial fibrillation									
19a DATE OF OPERATION 1/21/79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatic Hypertrophy + obstructions				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1978, to 1/4, 1979, that (I) (we) lost saw the deceased alive on 1/4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE S. Scalia				DEGREE MD				22c. DATE SIGNED 1/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. SCALIA				22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 1-8-79		23c NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		23d LOCATION CITY OR TOWN COUNTY STATE 7225 EASTERN BLVD., BA.CO., MD.			
24 FUNERAL DIRECTOR NAME Charles F. Giller & Son Inc.				25a DATE REC'D. BY REGISTRAR JAN 10 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



72-01032

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

79-01037

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR									
1. DECEASED NAME (TYPE OR PRINT)		2b. HOUR									
FIRST MIDDLE LAST		2c. DATE PRONOUNCED DEAD									
(Abraham) Abram A. Joyner		1 13 19 79									
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD					7d. HOUR
Male	Black	10 23 20	58 YRS.			1 13 19 79					8:10P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					MD.
North Carolina		U. S. A.				Baltimore City,					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City		735 W. Saratoga Street									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland				Baltimore				735 West Saratoga Street			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Abram Joyner				Bertha Hardy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No						Emmett Joyner		2110 Fulton Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>											
4292 } DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held at death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED					
<u>Thomas D. Smith</u>		M.D. Deputy Chief				1/14/79					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St. Balto., Md.							
Thomas D. Smith, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/20/79		Mt. Calvary Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H		1101 East North Ave.		JAN 17 1979		<u>W. C. March</u>					

10-01031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01038

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		1 16 79		11:45 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR 1 15 79		1 day - YRS. MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore City MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore City		Baltimore City Hospital					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
17 INFORMANT		ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				7798 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u>		1 hr	
				DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity</u>		4 hr	
						33 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>79</u> , to <u>1/16</u> , 19 <u>79</u> , that (I) (we) lost		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
saw the deceased alive on <u>1/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		Ethylis Wang Jabs MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/16/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. LOCATION CITY OR TOWN COUNTY STATE			
Ethylis Wang Jabs		Baltimore City Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Hospital Burial							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF REGISTRATION		25b. REGISTRAR SIGNATURE	
				JAN 24 1979		Ethylis Wang Jabs	

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*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4) 9/74)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01039 REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine A. JUNG</i>			MONTH DAY YEAR <i>JAN. 19. 1779</i>		<i>9 24 P.M.</i>
3 SEX <i>F</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>12/14/193</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10 CITY OR TOWN OF DEATH <i>Balto</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) <i>9629 Harding Ave</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>md</i>			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <i>George F. Ueberbeck</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Matilda Stange</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>218-22-4409</i>		17 INFORMANT ADDRESS <i>Waller D. Jung 9629 HARDING Ave</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1629</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>September, 19 78</i> , to <i>19 January, 19 79</i> , that (I) (we) lost saw the deceased alive on <i>18 January, 19 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <i>John W Barnaby M.D.</i>		DEGREE		22c. DATE SIGNED <i>23 Jan 79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN W BARNABY</i>		22e. ADDRESS <i>16525 Redden Ave</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/17/79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto Co.</i>
24. FUNERAL DIRECTOR NAME <i>McDeemans</i>		ADDRESS <i>6067 Harford Rd</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 25 1979</i>	25b. REGISTRAR'S SIGNATURE <i>Dorothy McCreedy</i>

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UNITED STATES DEPARTMENT OF AGRICULTURE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01040 REG. NO.		
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) <b>JESSE F. KALER</b>					2a. DATE OF DEATH MONTH <b>1</b> DAY <b>31</b> YEAR <b>79</b>			2b. HOUR <b>10:50 P.M.</b>				
3. SEX <b>MALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>18</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (AND IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Watchman</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>600 Light Street</b>	
14. FATHER'S NAME FIRST <b></b> MIDDLE <b></b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b></b> MIDDLE <b></b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-05-8847</b>		17. INFORMANT <b>Mrs. Minerva E. Kaler</b> ADDRESS <b>600 Light St. - 21230</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE INTRACEREBRAL BLEED - EMI SCAN</b> <b>431-</b> DUE TO, OR AS A CONSEQUENCE OF <b>Confirmed,</b> (b) <b>Hypertension,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> , 19 <b>79</b> , to <b>1/31</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/31</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>P. A. WILSON, M.D.</b>				DEGREE <b></b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/31/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. A. WILSON</b>				22e. ADDRESS <b></b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>			23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b> COUNTY <b></b> STATE <b></b>				
24. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>				

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FOR  
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REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01041  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Clyda</b> <b>Kaminski</b>		2a. DATE OF DEATH MONTH <b>01</b> DAY <b>02</b> YEAR <b>79</b>		2b. HOUR <b>1:20P</b> M	
3 SEX <b>female</b>	4 RACE <b>cauc.</b>	5 DATE OF BIRTH MONTH <b>11</b> DAY <b>27</b> YEAR <b>1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hosp.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>Md.</b>	
13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>3405 Noble St.</b>		14 FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Bowman</b> LAST <b>Bowman</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Gracie</b> MIDDLE <b>Shinault</b> LAST <b>Shinault</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-22-1112</b>		17 INFORMANT ADDRESS <b>Richard Kaminski 4609 Ritchie Hwy.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Cancer</b>					
19a. DATE OF OPERATION <b>12/20</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>78</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____		22a. I certify that (this hospital) attended the deceased from <b>12/20</b> 19 <b>78</b> to <b>102</b> 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>102/79</b> 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I <input checked="" type="checkbox"/> did: (a) view the body after death.		22b. SIGNATURE <b>Mark Hirsch</b> MD	
22c. DATE SIGNED <b>9/02/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Hirsch Korn</b>		22e. ADDRESS <b>Balto City Hosps</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>	
23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____		24. FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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DATE 01-11-2011 BY 10410-05

REASON FOR REVIEW



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01042 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA KANIECKI				MONTH DAY YEAR 01 30 79				9:25 A.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 31 92		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? POLAND		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FACTORY WORK		12b. KIND OF BUSINESS OR INDUSTRY PICKLE PACKING			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 905 S. POTOMAC ST. 21224			
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE							
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN Palowska							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 01 3756		17. INFORMANT MARGARET KANIECKI		ADDRESS 905 S. POTOMAC ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4241 DUE TO, OR AS A CONSEQUENCE OF b) AORTIC STENOSIS 10 years DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 20, 19 79, to JAN. 30, 19 79, that (I) (we) last saw the deceased alive on JAN. 30, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Egya Quaison-Jackey				DEGREE MD				22c. DATE SIGNED 1-30-79.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EGYA QUAISON-JACKY				22e. ADDRESS SOUTH BALTIMORE GEN. HOSP.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2.3.79		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Md.			
24. FUNERAL DIRECTOR NAME Raymond L. Kaczorowski				ADDRESS 3525 Fleet St.		25a. DATE REC'D. BY REGISTRAR FEB 2 1979		25b. REGISTRAR'S SIGNATURE Pitney Kelcey			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01043 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHRISTOPHER PAUL KAPPLE</b>				1-4-79 10 <sup>35</sup> P.M.			
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 29, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>70 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN CAN CO</b>	
13a. STATE <b>MD.</b>				13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST W. KAPPLE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA KERN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.I</b>		17. INFORMANT ADDRESS <b>501 N. ELLWOOD AVE. BALTO., 21205, MD.</b>		17. INFORMANT <b>LORIDA P. KAPPLE ;</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse, Sepsis</b> 2389 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOID TUMOR</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>79</b> , to <b>1-4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-4-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas H. Fletcher III</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-4-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS H. FLETCHER III</b>				22e. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-8-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL MEM. GDNS.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WHITE MARSH, BALTO. CO., MD</b>	
24. FUNERAL DIRECTOR NAME <b>Charles S. Giller &amp; Son, Inc.</b>				24b. ADDRESS <b>6224 EASTERN AVE. BALTO., 21224, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			



32-01043

1942.12.23

WHITE

1942

BALTIMORE CITY HOSPITALS

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01044

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank J. Karle			2a. DATE OF DEATH 1/15/79 MONTH DAY YEAR		2b. HOUR 4:30A M								
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 19 1901		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b KIND OF BUSINESS OR INDUSTRY Home Furnishings					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.						13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3022 Mayfield Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST Anthony Karle						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Roll							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no						16b SOCIAL SECURITY NO. 216-09-6913		17 INFORMANT ADDRESS Martha Karle (wife) same as 13					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> 1533 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE METASTATIC COLONIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADENOCARCINOMA OF THE SIGMOID COLON</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>78</u> , to <u>1/15</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Fredric Stewart Sirkis MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDRIC STEWART SIRKIS						22e. ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/18/79		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24 FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.						ADDRESS 2331 Brehms Lane Balto. Md. 21213		25. DATE REC'D. BY REGISTRAR JAN 18 1979		25b. REGISTRAR'S SIGNATURE Rufus McCready			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

44010-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01045 REC'D NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Mack Kasey</b>						2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> MONTH <b>Jan</b> DAY <b>13</b> YEAR <b>1979</b>		7b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>20</b> YEAR <b>1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		IF UNDER 24 HRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7c. DATE PRONOUNCED DEAD MONTH <b>January</b> DAY <b>13</b> YEAR <b>1979</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3030 Baker Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>			7d. HOUR <b>6:57A</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>3030 Baker Street</b>			14. FATHER'S NAME FIRST <b>Waitmond</b> MIDDLE <b></b> LAST <b>Kasey</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Hester</b> MIDDLE <b></b> LAST <b>Drew</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>224-36-6097</b>			17. INFORMANT <b>Hamler-Curtis F.H./</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>1002 Moorman Road N.W., Roanoke, Virginia</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>1/13/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal /Burial</b>				23b. DATE <b>Jan. 19, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Williams Memorial Park</b>				23d. LOCATION CITY OR TOWN <b>Roanoke</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Hamler-Curtis F.H./</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
ADDRESS <b>4101 Edmondson Ave./Balto. Md</b>				ADDRESS <b>1002 Moorman Rd./Roanoke, Va.</b>							

24010-85

MEDICAL EXAMINERS CASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

See by record - Dr. Korell - 11/1/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01046 REG. NO.	
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George A. Kaufman				2a. DATE OF DEATH MONTH DAY YEAR 11/1/79			2b. HOUR 5:25 P M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6 11 1901		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boston Mass		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. city MD.					
10. CITY OR TOWN OF DEATH Balt. MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lewinsky Gen. Cl. & Hsp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) meat cutter		12b. KIND OF BUSINESS OR INDUSTRY MEATS			
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. STREET ADDRESS 6810 Park Hgts. Ave.		APT. 409 #21215			
14. FATHER'S NAME FIRST MIDDLE LAST MAX KAUFMAN				15. MOTHER'S NAME FIRST MIDDLE LAST ETTA KAUFMAN				16. UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 049-03-7679		17. INFORMANT ADDRESS MRS. ETHEL KAUFMAN 6810 PARK HTS. AVE. APT. 409 #21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> 8809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Confusion + Fr Skull</u> (c) <u>Accidental Fall</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u> <u>6 weeks</u> <u>6 weeks</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 11/23/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Excision of Intracerebral Hemorrhage				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11 12 1978		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fall going upstairs - Fr skull & surgery							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) AT Home -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6810 Park Hgts. Ave. Balt. Balto Md 21215							
22a. I certify that (1) (this hospital) attended the deceased from 11/1/78 to 11/1/78, and that (1) (my) opinion death occurred on the date and hour and from the causes stated above, (1) (my) did not view the body after death.											
22b. SIGNATURE [Signature]				DEGREE M.D.				22c. DATE SIGNED 11/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. D. L. ST. M.D.				22e. ADDRESS Greenspring Belvedere A (21215)							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 2, 1979		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION BALTIMORE		COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JAN 4 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

10-01040





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01047 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ROXIE May Keaser</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 25 79</b>			2b. HOUR <b>8<sup>00</sup> P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc. White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 10 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cashier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Drive-in</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3701 Old North Point Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Johnson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Evans</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-40-7304</b>		17. INFORMANT <b>3701 Old North Point Rd. William E. Keaser-Balto. MD 21222</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNWITNESSED CARDIO PULMONARY ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>SIP INFERIOR WALL MI</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 19</b> , 19 <b>79</b> , to _____, 19 _____, that (I) (we) last saw the deceased alive on <b>JAN. 25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Leo J. Spaccavento</b> M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1-25-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEO J. SPACCAVENTO</b>					22e. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> NAME ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>				

BP

74010-02

Released - now - med by Dr. Holaw per Mr. Sawyer  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01048 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joseph Edward Keenan						2a. DATE OF DEATH MONTH DAY YEAR January 26, 1979				2b. HOUR 5:14pm	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 24, 1978		6 AGE (IN YEARS LAST BIRTHDAY) -----YRS. 9 2		IF UNDER 1 YEAR MONTHS DAYS 9 2		IF UNDER 24 HRS. HOURS MIN. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE Maryland						13b. COUNTY Howard		13c. CITY OR TOWN Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Edward Keenan						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Nixon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS John E. & Deborah Keenan same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biventricular heart failure</u> 7456 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Repair of atrio ventricular Canal Defect</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congenital Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 1-26-79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atrioventricular Canal				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:14 P.M. 1 26 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-26</u> , 19 <u>79</u> , to <u>1-26</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE STEVEN T. DEAK, M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-26-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN DEAK, M.D.						22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/30/79		23c. NAME OF CEMETERY OR CREMATORY Maryland National Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Co. Md.			
24 FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810						25a. DATE REC'D. BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE Anthony McCready			

79-01048

1. Name: [illegible]  
 2. Address: [illegible]  
 3. City: [illegible]  
 4. State: [illegible]  
 5. Zip: [illegible]  
 6. Date: [illegible]  
 7. Signature: [illegible]  
 8. Title: [illegible]  
 9. Organization: [illegible]  
 10. Remarks: [illegible]

11. Name: [illegible]  
 12. Address: [illegible]  
 13. City: [illegible]  
 14. State: [illegible]  
 15. Zip: [illegible]  
 16. Date: [illegible]  
 17. Signature: [illegible]  
 18. Title: [illegible]  
 19. Organization: [illegible]  
 20. Remarks: [illegible]

21. Name: [illegible]  
 22. Address: [illegible]  
 23. City: [illegible]  
 24. State: [illegible]  
 25. Zip: [illegible]  
 26. Date: [illegible]  
 27. Signature: [illegible]  
 28. Title: [illegible]  
 29. Organization: [illegible]  
 30. Remarks: [illegible]

10-3N 3 026 20 24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be retained within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01049

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
PAULINE W. KEENE			JANUARY 16, 1979			5:40A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		7. UNDER 24 HRS
Female	Negro	MONTH DAY YEAR 10 7 1922	56 YRS.			MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U. S. A.		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	THE JOHNS HOPKINS HOSPITAL							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS		
Douglas Johnson			Emma Farrah			1200 Canal Court Apt-A1		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
			213-14-7734			Frederick Keene 239 South Dallas Ct.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>left lung collapse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cat cell ca of lung</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hemolytic Anemia</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>79</u> , to <u>1/16</u> , 19 <u>79</u> . That (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Peter C. Holt MD</u>						1/16/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
PETER A. HOLT MD			JOHNS HOPKINS HOSP. BALTO. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			1/20/79		ENewmarket Cemetery Eastern, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H 1101 East North Ave.					JAN 17 1979 <u>Anthony McInerney</u>			

MEDICAL CERTIFICATION

29

BP

12-01043

45 05 350 E NE 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01050 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA E. C. KEFAUVER				2a. DATE OF DEATH MONTH DAY YEAR 1 11 79 11:15 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. STREET ADDRESS 1660 Belvedere Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar C. Kefauver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE May Schaeffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXXXXXXXX 217-10-0355		17. INFORMANT ADDRESS Mr. Irving S. Kefauver Brooklawn Apts. Frederick, Md. 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory arrest</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Central vascular accident</u> (c) <u>Arteriosclerotic and hypertensive cardiovascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> 19 <u>79</u> to <u>1/11</u> 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>4/10</u> 19 <u>79</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <u>C. S. Anderson M.D.</u>				DEGREE		22c. DATE SIGNED <u>1/11/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDERSON CRAIG S. ANDERSON, M.D.				22e. ADDRESS U-M-H UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (BURIAL) Burial		23b. DATE 1-15-1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY Frederick, Frederick, Mtf.	
24. FUNERAL DIRECTOR NAME Robert E. Bailey & Son, Frederick, Md.				25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



79-01020

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UNION MINERAL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01051 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST GERTRUDE VIRGINIA KELLEY				2b. HOUR 9:30 AM			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4/09/07		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY at Home	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Ellicott City	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Parrish			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 213 09 6207D		17. INFORMANT Clara Silva	
				2601 Westchester Ave. Ellicott City, Maryland 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis - peritoneum & Abcites Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U. SIVAN M.D.				22e. ADDRESS ST. AGNES HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/79		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Maryland	
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 22 1979 [Signature]			

12010-0

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

Address

City

State

Zip

ST AGNES HOSPITAL, BALTIMORE, MD.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 35

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01052	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 1-29-79						2b. HOUR 10 M
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELVA M Kelly											
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 22 94		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD					
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seton Hill Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Laundry			
13a. STATE Md					13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Martin Olsen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Hansen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 215-16-9794		17. INFORMANT ADDRESS Walter Olsen 4409 Falls Road 21211				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 486- Right Lower Lobe Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jamie M. Lungalan MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-30-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/1/79		23c. NAME OF CEMETERY OR CREMATORY Solomons Meth. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Solomon Is. Calvert Md				
24. FUNERAL DIRECTOR NAME Burgee Funeral Home					ADDRESS 3631 Falls Road 21211		25a. DATE RECEIVED BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE Motley, M. Brady		

73-01025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01053 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES PAULINE KELLY						2a. DATE OF DEATH MONTH DAY YEAR JAN. 26 79			2b. HOUR 130P M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md						13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Szeziuski						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Helinski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-05-1124		17. INFORMANT Mrs. Kelly		ADDRESS 509 N. East Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 8938 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) 31% body surface area burns DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CHRONIC ATRIAL FIBRILLATION/MITRAL VALVE DISEASE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. unk. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Smoking in bathroom					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.H.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Unk.					
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 19 79, to 1-26, 19 79, that (I) (we) last saw the deceased alive on 1-26, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. Accident											
22b. SIGNATURE William E. Vetter MD								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-26-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VETTER						22e. ADDRESS					
23a. BURIAL CREMATION REMOVAL (SPECIFY) Burial				23b. DATE 1-30-79		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, MD.			
24. FUNERAL DIRECTOR NAME Raymond L. Kaczorowski						25a. DATE REC'D. BY REGISTRAR FEB 2 1979		25b. REGISTRAR'S SIGNATURE L. J. Kelly			



50-01023



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01054 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>PHILLIP F. KELLY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 30 79</b>			2b. HOUR <b>1:00 AM</b>					
3 SEX <b>MALE</b>		4 RACE <b>CAUC</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6/2/34</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>44</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AIA FORCE</b>			
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1311 UNION AVE</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS F.</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE D.</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-32-4038</b>		17 INFORMANT ADDRESS <b>WIFE</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UGI bleeding</b> <b>5715</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>liver cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>1/28/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding esophageal varices</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/29/79</b> , 19 <b>79</b> , to <b>1/30/79</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Raul Diaz</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/30/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raul Diaz</b>					22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>				
24 FUNERAL DIRECTOR NAME <b>Paul E. Harwood</b>					ADDRESS <b>3617 Chestnut Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry Brady</b>		

42010-01

UNION MEMORIAL HOSPITAL

UNION MEMORIAL HOSPITAL

UNION MEMORIAL HOSPITAL

PR 36/1

PR 36/1

PR 36/1

PR 36/1

UNION MEMORIAL HOSPITAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. FOR PAGE 4, SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17  
(VR 15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01055  
REC. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2. DATE KNOWN OF DEATH		MONTH DAY YEAR	
ANNIE B. KENNEDY				1 15 19 79		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	
Female	Black	9 21 85	93 YRS.			1 15 19 79 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
South Carolina		U. S. A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH (Baltimore)		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		1032 Ashland Ct.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Sam McNeil		Diana McNeil					
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Willie Truxton		146 North Central		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>			
				DUE TO, OR AS A CONSEQUENCE OF			
				(b) <u></u>			
				DUE TO, OR AS A CONSEQUENCE OF			
				(c) <u></u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
<u>Margaret De Krell</u>		M.D. Assistant		1/15/79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
Margarita A. Korell, M.D.		111 Penn Street		Burial			
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
1/20/79		Westview Mem. Park		Catonsville, Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		JAN 17 1979		<u>Anthony McCreedy</u>			
Wm. C. March F/H 1101 East North Ave.							

22010-21

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01056

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PAUL - KENNEDY			2a. DATE OF DEATH MONTH DAY YEAR 11/3/79			2b. HOUR 9:15 A.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 18 23		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN'S HOPKINS HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
12b. KIND OF BUSINESS OR INDUSTRY Newspaper		13a. STATE Md.		13b. COUNTY --		13c. CITY OR TOWN Balto.	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1707 S. 25th St.					
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Kennedy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Duffy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-6175		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Death</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intra Cranial bleeding</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Body Signaled to Board</u>							
19a. DATE OF OPERATION 4/2/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra Cranial bleeding			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/2/79, 1979, to 1/3/79, that (I) (we) last saw the deceased alive on 1/2/79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE A.S. Farrukh				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1.3.79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.S. Farrukh				22e. ADDRESS John Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1-3-79		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS 655 W. Balto. St. Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 5 1979	
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: To be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

72-01026



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of a decedent be executed within 4 hours of death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01057	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) HELEN IRENE KEYES						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1979			2b. HOUR 02:58 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 1, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST O. C. Elliott						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia -- Mables					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-68-2115		17. INFORMANT ADDRESS Herbert L. Keyes, Joppa, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4299 DUE TO, OR AS A CONSEQUENCE OF (b) <u>V. tachycardia/V. fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 58 minutes 58 minutes ?											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>s/p pulmonary embolus, renal failure, congestive heart failure, peptic ulcer disease</u>											
19a. DATE OF OPERATION 1/28/79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pacemaker placement				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>79</u> , to <u>1/28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Anna Mae Diehl						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/28/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anna Mae Diehl						22e. ADDRESS Johns Hopkins Hospital - M.I.C.U.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 31, 1979		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh, Balto. Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR JAN 30 1979		25b. REGISTRAR'S SIGNATURE Ruthy K. Boney			

MEDICAL CERTIFICATION



72010-02

72010-02

72010-02



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01058

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>KICK</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 16 79</i>			2b. HOUR <i>7:45</i> M	
3. SEX <i>undeterminable</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 16 79</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>16 weeks</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N B</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>				13b. COUNTY		13c. CITY OR TOWN <i>21227</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Timothy M. Kick</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Doris L. Matusz</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurely 14-16 wk fetus. Non Visible</i> <i>7651</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-6</i> , 19 <i>79</i> , to <i>1-6</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>1-6</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Donald E. Garland DO</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/8/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Hospital Disposal</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 11 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Mary McCreedy</i>	

82010-02

1981-10-10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01059

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE J. LAST KING			2a. DATE OF DEATH MONTH DAY YEAR 01-24-79		2b. HOUR 21 <sup>00</sup> A.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 2-2-1925	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING.
13a. STATE MD.			13b. COUNTY —	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ALEX NAPLACHOWSKI			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FELICIA LEGACZYNSKA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-26-4349	17. INFORMANT ADDRESS Mr. Ignatius J. King - 5418 Bucknell Rd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cerebro-respiratory arrest

Massive lung parenchymal bleeding

Adeno-carcinoma of the lung

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joachim Fulek	DEGREE	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joachim Fulek	22e. ADDRESS	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-27-79	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.
24. FUNERAL DIRECTOR NAME Stanley Miller - 7527 Harford Rd.		25a. DATE REC'D. BY REGISTRAR JAN 26 1979	25b. REGISTRAR'S SIGNATURE Ruthy McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

72-01022

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01060 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Ollie E. Kinsler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 19 79</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Female</b>		4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 4 11</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>67</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>512 Allendale Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward I. Black</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Harris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-22-9695</b>		17. INFORMANT ADDRESS <b>Clarence Kinsler S/A</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>15 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>PM 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>June 11, 19 64</b> to <b>Jan 4 19 79</b> , that (1) (we) lost saw the deceased alive on <b>Jan 4 19 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Samuel R. Owings, Jr., M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Jan. 22, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Samuel R. Owings, Jr.</b>		22e. ADDRESS <b>909-11 N. Carey St. Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Bethel AME CH.</b>	
23d. LOCATION CITY OR TOWN <b>Columbia</b>		COUNTY <b>S.C.</b>		STATE <b>S.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Charles H. Powell</b>		ADDRESS <b>319 N. Schroeder St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01061 REG. NO.		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		DORA				KIRSCHBAUM	1.28.79					12:40 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		CAUCASIAN		12-08-00		78 yrs		MONTHS		DAYS		
								HOURS		MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
MARYLAND		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BALTIMORE CITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		SINAI HOSPITAL				HOUSEWIFE		AT HOME				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4000 FORDS LA., APT. 1-C #21215				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
MORRIS				RACHEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO				212-22-9607A		GEORGE KIRSCHBAUM 4000 FORDS LA. #21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
410- Cardio respiratory Arrest										15 min.		
DUE TO, OR AS A CONSEQUENCE OF (b)												
AC. Infarct MI -										12 hr.		
DUE TO, OR AS A CONSEQUENCE OF (c)												
AC. Cardiogenic shock.										8 hr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR								
				P.M.		19						
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from JAN. 27 19 79, to JAN. 28 19 79, that (we) last saw the deceased alive on JAN 28 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.												
22b. SIGNATURE				DEGREE				22c. DATE SIGNED				
Ruth Chacko M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1.28.79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS								
RUTH CHACKO, M.D.				SINAI HOSPITAL OF BALT.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE				
BURIAL		JAN. 30, 1979		BNAI ISRAEL		BALTIMORE		MARYLAND				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
SOL LEVINSON & BROS., INC.						FEB 1 1979		Ruth Chacko				
6010 REISTERSTOWN RD., BALTO., MD 21215												

BP

10010-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01062	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST BAXTER KIRVEN					MONTH DAY YEAR 1 28 79					8:35 AM	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		Black		MONTH DAY YEAR 3 11 1918			60		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
South Carolina		U. S. A.				Baltimore MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		VAMC, Baltimore, Maryland 21218								12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE										13b. COUNTY	
Maryland										Baltimore	
13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?	
Baltimore										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Robert Kirven										FIRST MIDDLE LAST Ophelia Dials	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.	
Yes WWII										4280	
17 INFORMANT										ADDRESS	
VAMC Records, Baltimore, Maryland 21218											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRASH RESPIRATORY THEN ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>? PULM EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF, CUPO</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>immediate</u> <u>yes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>February 26</u> , 19 <u>79</u> , to <u>February 28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>February 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Steven H. Resnick MD</u>								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/29/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEVEN H. RESNICK</u>								22e. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial				1/31/1979		Church Cemetery			Darlington, S. C.		
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March F/H 1101 East North Ave.</u>											
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 30 1979</u> <u>Stephen H. Resnick</u>											

78-01025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01063	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MALE KISNER					2a. DATE OF DEATH MONTH DAY YEAR 1 30 79			2b. HOUR 7:10 AM			
3. SEX MALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 1 29 79		6. AGE (IN YEARS LAST BIRTHDAY) 7 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7989 Willow Oak Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Rickie LYNN Kisner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis Marie Skarzynski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Mother			ADDRESS Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> 7798 DUE TO, OR AS A CONSEQUENCE OF (b) <u>IMMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>79</u> , to <u>1-30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. L. Macanaleg</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. L. MACANALEG				22e. ADDRESS S BGT							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/8/79		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REG'D. BY REGISTRAR FEB 13 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

33010-21



CHIEF OF POLICE

POST OFFICE BOX 1185



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01064 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD G. KLEIN				JANUARY 29, 1979				10:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 2, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gustave Klein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Aurelia Schott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT Mrs Mary Klein		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 5307 } DUE TO, OR AS A CONSEQUENCE OF (b) UPPER GASTROINTESTINAL BLEEDING (c) DUE TO, OR AS A CONSEQUENCE OF MALLORY WEISS SYNDROME 24 HOURS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 1-28-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UPPER GASTROINTESTINAL BLEEDING				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 1-28 19 79, to 1-29 19 79, that (1) (two) last saw the deceased alive on 1-29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)									
22b. SIGNATURE Y. K. S. SNEYDY, M.D.		DEGREE M.D. B.S. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-29-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Y. K. S. SNEYDY, M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/79		23c. NAME OF CEMETERY OR CREMATORY Moreland Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 2 1979		25b. REGISTRAR'S SIGNATURE F. J. Kelly	



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S. L. J.

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RIE, S. 30A

### DISCUSSION

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Salisbury, Maryland

REVIEWS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01065	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR	
LENA			KLEIN			1-7		79		2:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAUCASIAN		3 17 85		93		MONTHS		DAYS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
LATVIA		U.S.A.				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			LEVINALE HEBREW HOME			HOUSEWIFE			AT HOME		
13a. STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13d. ADDRESS		
MARYLAND			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4306 1st Fl #21215		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
ISAAC			SCHUMAN			YETTA					
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF			19. SOCIAL SECURITY NO.					
LEON KLEIN			6317 PEARCE AVE. #21215			213-54-4997					
20. DATE OF OPERATION			21. CONDITION FOR WHICH OPERATION WAS PERFORMED			22. AUTOPSY?			23. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
410-			Acute Myocardial Infarction			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			1 month								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			ASAD								
24. DATE OF OPERATION			25. TIME OF INJURY			26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19 79			19 79			19 79			19 79		
28. I certify that (I) (this hospital) attended the deceased from above (we) did not view the body after death.			29. SIGNATURE			30. ADDRESS			31. DATE SIGNED		
			NOEL D. C. (ST MD)			Greenpines Belvedere Ave 21215			1/7/79		
32. BURIAL, CREMATION, REMOVAL (SPECIFY)			33. DATE			34. NAME OF CEMETERY OR CREMATORY			35. LOCATION		
BURIAL			JAN. 8, 1979			BNAI ISRAEL			BALTIMORE		
36. FUNERAL DIRECTOR			37. DATE REC'D. BY REGISTRAR			38. REGISTRAR'S SIGNATURE			39. COUNTY		
SOL LEVINSON & BROS., INC.			JAN 12 1979			Dietrich K. K. K.			MARYLAND		
6010 REISTERSTOWN RD., BALTO., MD 21215											

BP

*[Faint, mostly illegible handwritten text and markings, possibly including a signature and various notations.]*

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01066 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL KLEIN</b>				2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>27</b> YEAR <b>79</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>07</b> DAY <b>11</b> YEAR <b>00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sing. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GLASS Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				#21215			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6970 MARSUE DR., APT. 1-D</b>	
14. FATHER'S NAME FIRST <b>TEVYEH</b> MIDDLE <b>KLEIN</b> LAST <b>FAIGA</b>				15. MOTHER'S MAIDEN NAME FIRST <b>FAIGA</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-03-7957A</b>		17. INFORMANT <b>MRS. SOPHIE KLEIN</b>		6970 MARSUE DR. APT. 1-D #21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SIP pul. edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Probable sepsis.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <b>edema CA of colon, ASCVD, AODM, SIPM Vx2, recent hematuria.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> , 19 <b>79</b> , to <b>1/27</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Bruce E. Johnson, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce E. Johnson</b>				22e. ADDRESS <b>Sing. 9014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 29, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
6010 REISTERSTOWN RD., BALTO., MD 21215							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01067  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>JOHN THOMAS KLINE, JR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>01-24-79</b>		2b. HOUR <b>8<sup>50</sup> PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sunpapers Co</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Kline, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Gilmore</b>		13e. STREET ADDRESS <b>2800 Kentucky Ave. 21213</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II</b>		17. INFORMANT ADDRESS <b>James S. Kline (brother) same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIPLOCOCCAL MENINGITIS</b> <b>0360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>S/P (L) CRANIOTOMY/LOBECTOMY</b>							
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>01-16-79</b> to <b>01-24-79</b> , that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kendall R. Faulkner</b> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/24/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FAULKNER</b>				22e. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE, MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>St. Edmund Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Tracy A. Crosby</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

78010-07



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01068 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Crook Klutz</b>						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 12 19 79</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>67</b>		7. IF UNDER 24 HRS. HOURS MIN <b>00 00</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		2c. DATE PRONOUNCED DEAD <b>1 12 19 79</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>613 Pitcher Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Barber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Barbering</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>613 Pitcher Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Klutz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Caldwell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-18-9683</b>		17. INFORMANT ADDRESS <b>Christopher C. Johnson 3506 Holmes Ave. (Brother)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 429.2 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on, Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>1/13/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jonesville Church Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mackelbury County, N. C.</b>				
24. FUNERAL DIRECTOR NAME <b>Donald E. Glover</b>				ADDRESS <b>802 Madison Ave. 21201</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1979</b>		25b. REGISTRAR'S SIGNATURE <i>L. H. H. H.</i>			

83010-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01069  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Edward J. Knach			ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 28 19 79			M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 24 YRS. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD			7d. HOUR
male	white	Dec. 10, 1911	67 YRS.		1 28 19 79			12:12 a M
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, Maryland		U.S.A.				Baltimore City MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		at home/2012 Eastern Avenue			Retired Standard		oil co.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland				Baltimore		2012 Eastern Avenue 21231		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
William Knach				Carrie Mrozinski				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes WWII				214-01-4392		Mrs. Helen P. Knach, 2012 Eastern Ave. 21231		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4392 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 1/28/79		
EXAMINER'S NAME (TYPE OR PRINT) VIRGINIA L. DOLAN, M.D.			ADDRESS 111 Penn Street, Balto, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		Jan. 31, 1979		Holy Rosary Cemetery		Baltimore, County Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
M.F. Sadowski & Sons, 1808 Eastern Avenue 21231				JAN 30 1979		<u>Henry McCurdy</u>		

92-0100

92-0100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01070 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles Leonard KNIGHT</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 15 79</b>		2b. HOUR <b>3:21</b>		AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 19, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>723 E. Lake Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Sherman Knight</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jane Leonard</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>705-03-4498</b>		17. INFORMANT ADDRESS <b>Mrs. Charles L. Knight</b>				Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart Failure</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>79</b> , to <b>1/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James D. Gallant M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/15/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES D. GALLANT M.D.</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					
4905 York Road Balto., Md. 21212											

MEDICAL CERTIFICATION

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19-01070

UNITED STATES

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 79-01071

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
John J. Knoerr		1 30 19 79		1:15 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
male	white	Nov. 8, 1901	77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		40 East Cross Street		Clerk	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Jacob J. Knoerr		Catherine A. Leahy		213-28-2437	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW II		Julia A. Knoerr, 2525 Harlem Ave. 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Arteriosclerosis cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22b. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		1/30/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street, Balto., MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/3/79		Holy Cross Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Hubbard Funeral Home, Inc.		4107 Wilkens Ave.		FEB 2 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
		R. H. McCreedy			



15010-02

#23c g 28 2/9/79 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01072

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Osie (OASIE)		FIRST 2		MIDDLE		LAST KNUCKLES		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1979		2b. HOUR 14:30P	
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 12 5 1905		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1909 Oakhill Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Asa Knuckles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Shippy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII				16b. SOCIAL SECURITY NO. 237-03-5760		17 INFORMANT ADDRESS Mable Knuckles 1909 Oakhill Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Staphylococcal Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Oat Cell Ca										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12hrs 12hrs 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1/28, 1979, to 12/2/79, that (I) (we) lost saw the deceased alive on 1/28 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles Schron				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Schron				22e. ADDRESS Johns Hopkins Hospital 601 N. Bway Balt Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill - Balto. Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland					
24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.				ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 29 1979		25b. REGISTRAR'S SIGNATURE P. H. McBratney			

78-01075

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01073 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wayne M. Koerber			2a. DATE OF DEATH MONTH DAY YEAR 1/13/79		2b. HOUR M
3 SEX M	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 29 34		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Emergency Room		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY ASP Wkrs.
13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST George A. Koerber			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna B. Froeblich		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-58		17 INFORMANT ADDRESS Laura E. Owens Koerber 5556 Carville Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4140 } DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arter. H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>67905</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>75</u> , to <u>1/13</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. Edward Leach, M.D.				22c. DATE SIGNED 1/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 14 E. Eager St	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/16/79		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard Md.		24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd.			
25a. DATE REC'D. BY REGISTRAR JAN 16 1979				25b. REGISTRAR'S SIGNATURE [Signature]	

13-01073

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE THE CERTIFICATE, FORWARD TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01074 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Albert J. Koet</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 12 19 79</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar 30 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 13 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1937 Maisel Street / 21230</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>enamel co.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1937 Maisel Street / 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert J. Koet</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>May N. Stein</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW-II</b>				16b. SOCIAL SECURITY NO. <b>219-07-9962</b>		17. INFORMANT ADDRESS <b>Gladys Armstrong/417 Rosecroft Terr./21229</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b> 402- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>M.D. Deputy Chief</b>				DATE SIGNED <b>1/14/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>01/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Maryland 21228</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walters Funeral Home/Pratt &amp; Stricker Streets 21223</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01075 REG. NO.	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIAN R. Kohlhepp</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1/21/79</b>		2b. HOUR <b>8: P<sub>M</sub></b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>February 17, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chruch Home Inc.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>R tired clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dep't Store</b>			
13a. STATE <b>Ohio</b>		13b. COUNTY		13c. CITY OR TOWN <b>Cincinnati</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7058 Paddison Road</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>late Harry Mohrmeyer</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Mary</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>271 12 1250</b>		17. INFORMANT ADDRESS <b>James R. Kohlhepp 7058 Paddison Rd Cincinnati Ohio</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Colonic cancer with widespread metastasis</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>79</b> , to <b>1/21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/21/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. Bertram</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/21/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. BERTRAM, M.D.</b>						22e. ADDRESS <b>CHURCH HOME, INC. 100N. BROADWAY</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 23, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Memorial</b>		23d. LOCATION CITY OR TOWN <b>Howard, Maryland</b>		STATE			
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b>						ADDRESS <b>Columbia Road Ellicott City</b>		25a. DATE REGD. BY REGISTRAR <b>JAN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

72-01072

MARIA	R. Kohnke	1/27/33	6
Female	White	February 17, 1913	25
Ohio	U.S.A.		
Religious	Church Home Co.		
Card	1051		
John Henry	John Henry		
7/1 12 1250	James R. Kohnke	7/1 12 1250	

RESPIRATORY ARREST

Colonial pendant with widespread mark  
mesodermic

CHURCH HOME, INC. 100N. BROADWAY

BERMAN, W.D.

100N. BROADWAY

100N. BROADWAY

100N. BROADWAY

100N. BROADWAY

100N. BROADWAY

100N. BROADWAY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01076 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	MIN.
Dora		Kohn						1		30	79	2	23	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.				
FEMALE		WHITE		7 15 1918		80 84 YRS.		MONTHS		DAYS		HOURS		MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH								
RUSSIA		USA				Baltimore City								MD.
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE		SINAI HOSPITAL		HOUSEWIFE		AT HOME								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2500 W. BELVEDERE AVE. #21215				
14 FATHER'S NAME		MIDDLE		15 MOTHER'S MAIDEN NAME		MIDDLE								
MARCUS				GOLDBERG		LENA						UNKNOWN		414
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS								
NO		212-30-2420D		ALVIN KOHN		3509 ROCKDALE CT. #21207								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. } (b) <u>Respiratory Distress</u> (c) <u>Pneumonia, Pleural Effusion, CHF</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> , 19 <u>79</u> , to <u>1/30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/30</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>F.B. Neasman, II MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/30/79</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
F.B. NEASMAN, II MD		Sinai Hosp. & Balto.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
BURIAL		JAN. 31, 1979		BETH ISAAC ADATH ISRAEL		BALTIMORE								
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
SOL LEVINSON & BROS., INC.		6010 REISTERSTOWN RD., BALTO., MD 21215		FEB 1 1979		Rickey McCready								

13-01018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01077

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
ANTHONY J KOLLAR		JANUARY 15, 1979		8:10A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Male	White	June 13, 1909	70	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Illinois	U.S.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	THE JOHNS HOPKINS HOSPITAL		Ret. Mechanic		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Dor.	Cambridge, R.	NO <input checked="" type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rural R.D. 3
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST			FIRST MIDDLE LAST		
Joseph Kollar			Catherine Pehur		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		217-09-0868	Mrs. Maude Webster, Linkwood, Md., 21835		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>					3 min
1990					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Epidemic</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 27</u> 19 <u>78</u> , to <u>Jan 5</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>Jan 5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Mark A. Levine</u>		MD		<u>1/6/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>Mark Levine MD.</u>		<u>Johns Hopkins</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 17, 1979		Dorchester Mem. Park, Cambridge, Dor., Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
<u>Fernando R. Roman</u>		<u>Cambridge, Md.</u>		<u>JAN 19 1979</u>	
				25b. REGISTRAR'S SIGNATURE	
				<u>[Signature]</u>	

KOLLAR, ANTHONY J.  
185-45-92  
BALTIMORE, MARYLAND 21201

78-01077

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01078

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE NAOMI KOUBIK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/9/79</b>			2b. HOUR <b>2:04 A</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 22, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>404 Alameda Parkway</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Coleman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Gardner</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-07-6228</b>				17. INFORMANT ADDRESS <b>Hugo F. Loubik, 404 Alameda Parkway</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> 1953 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Metastatic Bronchitis Lung</b> (c) <b>CA Pelvis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/12/15</b> 19 <b>78</b> to <b>1/9</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1/8</b> 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <b>J. Mendoza</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/9/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JESUS MENDOZA</b>			22e. ADDRESS <b>900 S. CATON AVE-BALTO., MD 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/12/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian Cemetery Co., Baltimore</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Witzke Catonsville Funeral Home, P.A.</b>			1630 Edmondson Ave., Catonsville, Md			25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Kennedy</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



79-01078



BALTIMORE CITY

BALTIMORE SAINT AGNES HOSPITAL

X

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X

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X

300 S. CATON AVE-BALTO., MD. 21225

JAN 1 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01079 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST ADOLPH KOWALEWSKI		2a. DATE OF DEATH MONTH DAY YEAR 01 20 79	
3 SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 28 1900	
6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		8 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		10 CITY OR TOWN OF DEATH BALTO.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME + HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRANE OPERATOR		12b KIND OF BUSINESS OR INDUSTRY RET. RED.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.		13b COUNTY BALTO.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13d STREET ADDRESS 940 S. EAST AVE.	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO. 215-074510		17. INFORMANT JOSEPHINE KERDETENOGLO		ADDRESS SAME	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 42779 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Arrhythmia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 1/19/79		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1/19/79	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from 1/19/79, 19 79, to 1/20, 19 79, that (I) (we) lost saw the deceased alive on 1/19, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a. SIGNATURE DEGREE Walker A Impagliaelli	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Walker A Impagliaelli		22c. ADDRESS Church Home, 100 N. Broadway		22d. DATE SIGNED 1/20/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-23-79		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		24. FUNERAL DIRECTOR NAME THOMAS J. SKARDA		25a. DATE REC'D. BY REGISTRAR JAN 24 1979	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S SIGNATURE [Signature]		25d. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01080 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KUNIGUNDE G. Kracht				January 1, 1979			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2903 Pinewood Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Gick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-14-2765		17. INFORMANT Husband: ADDRESS Balt., Md. 21214 Walter F.R. Kracht 2903 Pinewood Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart disease</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>with hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1973 1969							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 9</u> 19 <u>50</u> to <u>January 1</u> 19 <u>79</u> , that (we) last saw the deceased alive on <u>January 1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Edward J. Alessi</u> DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Edward J. Alessi M.D.				22e. ADDRESS 6217 Harford Road Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 5 1979		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 4 1979	
25b. REGISTRAR'S SIGNATURE <u>Robert H. Brady</u>							

08010-02



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01081

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vivian G. Kroll</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 13 79</b>			2b. HOUR <b>10:05 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oil City, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ruffer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Factory</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>132 N. Linwood Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward P. Miller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bina Ruth Hazen</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>190-16-5559</b>		17. INFORMANT ADDRESS <b>Oil City, Pa. 16301. Mrs. Bina Ruth Miller-228 Mylan St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Cardiac Arrest</b> IMMEDIATE CAUSE (a) <b>0384</b> DUE TO, OR AS A CONSEQUENCE OF <b>Gram Negative Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/09/</b> , 19 <b>79</b> , to <b>1/13/</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/13</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <b>J. Bertram</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. J. Bertram</b>				22e. ADDRESS <b>CHURCH HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Peter's Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Utica, Penna.</b>			
24. FUNERAL DIRECTOR NAME <b>John A. Moran, Inc.</b>				ADDRESS <b>3000 E. Baltimore St.</b>				25a. DATE REC'D. BY REGISTRAR <b>Jan 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

18010-01



100%

100%





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH: 17  
(VR A15 ME (S))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01082 REG. NO.			
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leroy A. Krout</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 1 19 79</b>		2b. HOUR <b>M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 22 1918</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>60</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 1 19 79</b>		7d. HOUR <b>6:28A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bar Tender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2915 Eastern Blvd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LeRoy Albert Krout</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace A. LaMotte</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-09-6061</b>		17. INFORMANT <b>Bonita Gordy, R.D. #3, Stewartstown, Pa. 17363</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio cerebral injuries</b> 8842 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:30x 12 29 1978</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject fell off bar stool</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>bar</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2919 Eastern Blvd. Balto. Md.</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1/1/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn St. Balto., Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-3-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Freedom Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>New Freedom, York, Penna.</b>			
24. FUNERAL DIRECTOR NAME <b>James J. [Signature]</b>				ADDRESS <b>New Freedom, Penna.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

58010-01

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01083

REG. NO.

1. FOR STATE REGISTRAR						79-01083 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <div style="text-align: center;">CASIMER KUCINSKI</div>					2a. DATE OF DEATH January 8, 1979				2b. HOUR 2:30 A. M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH February 16, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4320 Clareway 21213				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr. of Kitchen Center Childrens		12b. KIND OF BUSINESS OR INDUSTRY St. Md.	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4320 Clareway 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Kucinski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-4102		17. INFORMANT Mrs. Anna Kucinski, 4320 Clareway 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial infarction</i> (c) <i>209</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>TBC - since 1936</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 6 1979</i> to <i>Jan 6 1979</i> , that (I) (we) lost saw the deceased alive on <i>Jan 6 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph B. Gons</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>Jan 8 1979</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph B. Gons</i>				22e. ADDRESS <i>600 Preston Rd 21208</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME M.F. Sadowski & Sons, 1808 Eastern Ave. 21231				25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE <i>Robert A. Cuddy</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7a-01083

7a-01083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

BP

DHMH-16 50M 7/77  
(VRA 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR					DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01084 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE W. KYLE					2a. DATE OF DEATH MONTH DAY YEAR 1/31/79			2b. HOUR 1:07 P.M.
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR 4/22/09		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED MACHINE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD M. KYLE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GWEN HARRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 214/07/1116		17. INFORMANT ADDRESS MRS. MABEL KYLE, FROSTBURG MD.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE 396- DUE TO, OR AS A CONSEQUENCE OF (b) DURING DOUBLE VALVE REPLACEMENT DUE TO, OR AS A CONSEQUENCE OF FOR (c) MITRAL INSUFFICIENCY STENOSIS & AORTIC STENOSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).								
19a. DATE OF OPERATION 1/31/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MITRAL INSUFFICIENCY, STENOSIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 1/31/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE S. KOEHLER MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/31/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. KOEHLER				22e. ADDRESS UNIV. HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB 4 1979		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD.		
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME				ADDRESS FROSTBURG MD.		25a. DATE REC'D. BY REGISTRAR FEB 8 1979		
				25b. REGISTRAR'S SIGNATURE [Signature]				

19-01084

1/1/19

Kyle

George

1/1/19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01085 REG. NO.																													
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR																											
1 DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					January 10, 1979					P. M.																								
3 SEX					4 RACE					5 DATE OF BIRTH					6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS																				
Female					White					8 MONTH DAY YEAR 29 1904					73 YRS.		MONTHS DAYS		HOURS MIN.																				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH					MD.																			
35 Maryland					U.S.A.										Baltimore City																								
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY																								
40 Baltimore					St. Agnes Hospital					Housewife																													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS																			
35 Maryland					A.A.					Linthicum					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					26 Eleanor Avenue																			
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME																																		
120 Harry					Wetzel					Bertha																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17 INFORMANT					ADDRESS																								
2 No					217-05-8510					Fred T. Kyle					SAME AS 13e																								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Chronic Degenerative Cardiovascular Disease</u>																													
										DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																								
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																													
					P.M. 19																																		
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION					CITY OR TOWN COUNTY STATE																								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										STREET																													
22a. I certify that (I) (this hospital) attended the deceased from Jan 1965, 19 65, to Jan 10, 19 79, that (I) (we) last saw the deceased alive on 1/4/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										DEGREE										22c. DATE SIGNED																			
Mario J. Reda M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										1/11/79																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																													
Mario J. Reda, Sr., M.D.										4016 Ritchie Hgwy., Baltimore (21225)																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION					CITY OR TOWN COUNTY STATE																			
Burial					1/13/79					Glen Haven Mem. Pk.					Glen Burnie A.A. Maryland																								
24 FUNERAL DIRECTOR										25. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
George J. Gonce										4001 Ritchie Highway										JAN 12 1979										R. J. Gonce									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01086 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Harry LACHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 10 1979</b>		2b. HOUR <b>11:35A</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 1, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mattress Maker- Bed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Spring</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <b>Maryland -</b>		13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3319 Shannon Drive 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Lacher</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Schott</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>		16b. SOCIAL SECURITY NO. <b>215-01-8941</b>		17. INFORMANT ADDRESS <b>Ruth Fischer (dgtr) same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteroseptal Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>January 8</b> , 19 <b>79</b> , to <b>January 10</b> , 19 <b>79</b> , that <del>or</del> (we) last saw the deceased alive on <b>January 10</b> , 19 <b>79</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Clifford Malanowski, M.D.</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1-10-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clifford Malanowski, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/13/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Schuminek Funeral Home, Inc.</b>		3321 Brehms Lane <b>Balto. Md. 21213</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Fiftyshelby</b>

13-01088

(M)

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01087			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George W. LaMar, Sr.				2a. DATE OF DEATH January 31, 1979		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 25, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3728 St. Victor Street 21225		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Const.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore			
14. FATHER'S NAME George T. LaMar				15. MOTHER'S MAIDEN NAME Amelia Dasch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215 05 5237		17. INFORMANT 3728 St. Victor Street Shirley Garland Baltimore, Md. 21225	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 402- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertensive, arteriosclerotic heart dis</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Innocent Nwankwue, M.D.				22e. ADDRESS 936 Patapsco Ave., Balto-25			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 3, 1979		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Maryland	
24. FUNERAL DIRECTOR NAME McGully Funeral Home of Brooklyn Balto., Md. 21225				25a. DATE REC'D. BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE Helen McCreedy	

78010-27

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01088

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERMA M. LANCASTER			2a. DATE OF DEATH MONTH DAY YEAR Jan 15 79			2b. HOUR 4:20 A.M.	
3 SEX F.		4 RACE B.		5. DATE OF BIRTH MONTH DAY YEAR 10 27 30		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY BALT.		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD DIGGS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY PROCTOR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS GEORGE LANCASTER SR - SAME AS #13	

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>3 TERMINAL - CG LUNG &amp; MEET</u>			
DUE TO, OR AS A CONSEQUENCE OF <u>8686 two week nodop.</u>			
(c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> 19 <u>75</u> to <u>Jan 15</u> 19 <u>79</u> . That (I) (we) last saw the deceased alive on <u>Jan 15</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sh. Ahmad.</u>		DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/79-4:20 PM	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SWARAN K. AHMAD.		22e. ADDRESS 2600 Liberty Hts. Ave. 21215.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-20-79		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND MD.	
24. FUNERAL DIRECTOR NAME H. Washington Sons 4925				ADDRESS N. Anne H. Burroughs		25a. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE JAN 19 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

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DEPT. OF AGRICULTURE  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01089 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST LAST LEE OLA LANCE		2a. DATE OF DEATH MONTH DAY YEAR 1-16-79		2b. HOUR 8:35 AM	
3. SEX FEMALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR MAY 2 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87 YEARS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY of BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Textile Worker		12b. KIND OF BUSINESS OR INDUSTRY Factory
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTO	13d. STREET ADDRESS 3212 Sidney Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES MARION LAMER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARLEY M. CRUMP			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT (Name) ADDRESS MRS DORAH POWERS SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Ischemia</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic Cardiovascular disease</u> (c) <u>Chronic renal failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic renal failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-14-1979 to 1-16-1979, that (I) (we) lost saw the deceased alive on 1-15-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE MD		22c. DATE SIGNED 1-16-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA		22e. ADDRESS 1600 MT Royal Ave, Balto. MD 21217			
23a. BURIAL, CREMATION, REMOVAL (SP) <u>BURIAL</u>		23b. DATE 1-19-1978		23c. NAME OF CEMETERY OR CREMATORY WEST HILL	
23d. LOCATION CITY OR TOWN COUNTY STATE DARTON Whitefield GA.		24. FUNERAL DIRECTOR NAME ADDRESS E BARNES FLEMING Funeral Service, Benson, MD			
25a. DATE REC'D. BY REGISTRAR JAN 17 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

28-01088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01090 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen MARIE Landmeyer						2a. DATE OF DEATH MONTH DAY YEAR 01/30/79		2b. HOUR 3:07 AM	
3. SEX F		4. RACE W. WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 30 19		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virgin Isl		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6145. Patterson Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST NIELS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE GONZALEZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. —		17. INFORMANT NINA E. Trott		ADDRESS 1000 MADISON ST ANNAPOLIS, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septic Shock 5340 DUE TO, OR AS A CONSEQUENCE OF (b) Abdominal Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 30 min. 5 hrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gastric Carcinoma - metastases to omentum. Acute GI Bleed & ulcer.											
19a. DATE OF OPERATION 1/28/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute GI ulcer.				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I (this hospital) attended the deceased from January 28, 1979, to January 30, 1979, that I (we) lost saw the deceased alive on January 30, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Adam Billet MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adam Billet				22e. ADDRESS Univ. of Md. Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/79		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD.					
24. FUNERAL DIRECTOR NAME John M. Taylor				ADDRESS Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE Kristy McCreedy	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01091  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK ROBERT LANG</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 8 1979</b>		2b. HOUR <b>5:52 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 5 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>US PUBLIC HEALTH SERVICE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PHYSICIAN RET.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK LANG</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY WOLFE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1923-1950</b>	
17. INFORMANT ADDRESS <b>WOLFE SAME</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DO NOT AS A CONSEQUENCE OF b) <b>RESPIRATORY FAILURE</b> DO NOT AS A CONSEQUENCE OF c) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>2 Hours</b> <b>YEARS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>PARKINSON'S DISEASE</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>—</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 7, 1979</b> to <b>JAN 8, 1979</b> , that (I) (we) lost saw the deceased alive on <b>JAN 8, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <b>Artemio Miranda, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-8-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTEMIO MIRANDA, MD</b>		22e. ADDRESS <b>US PHS Hospital, Bldg, MD 21211</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/ /79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd.</b>		25. DATE RECD. BY REGISTRAR <b>JAN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12010-21



REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b>		FIRST <b>E</b>		MIDDLE <b>LARKIN</b>		LAST <b>LARKIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1/29/79</b>		2b. HOUR <b>11:59 PM</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 28 1911</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>67</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>12 29</b>		8. IF UNDER 24 HRS HOURS MIN. <b>59 00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Charwoman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Lehrer</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Hurley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-01-8446</b>		17. INFORMANT <b>Regina Larkin/320 S Gilmor St/21223</b>		17. ADDRESS <b>320 South Gilmor Street 21223</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 514- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Peripheral Vascular ds; past CVA</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>30</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/15/78</b> 19 <b>78</b> , to <b>1/30/79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/30/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ellen Shapiro MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>1/30/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELLEN SHAPIRO</b>						22e. ADDRESS <b>601 N BROADWAY BALT</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>02/02/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Walters Funeral Home/Pratt &amp; Stricker Streets</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS 201 W. PRESTON ST. BALTIMORE, MARYLAND 21202-26



72-01035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <b>79-01093</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN W. LAUTERBACH Sr.</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>4</b> YEAR <b>1979</b>			2b. HOUR <b>8:28 PM</b>					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>July</b> DAY <b>11</b> YEAR <b>1927</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		8 IF UNDER 24 HRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contract Cleaners-Cleaning</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>500 Seminole Avenue</b>			
14 FATHER'S NAME FIRST <b>Maynard</b> MIDDLE <b>F.</b> LAST <b>Lauterbach, Sr.</b>						15 MOTHER'S MAIDEN NAME FIRST <b>Mura</b> MIDDLE <b></b> LAST <b>Chapman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>216-20-9465</b>		17 INFORMANT <b>500 Seminole Ave.-Catonsville</b> <b>Mrs. Vera K. Lauterbach-Md. 21228</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Coronary Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> , 19 <b>79</b> , to <b>1/4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>James P. Evans M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/4 1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Evans M.D.</b>						22e. ADDRESS <b>1132 N. Rolling Rd. Catonsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>					
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate</b> ADDRESS <b>736 Edmondson Ave. Catonsville, Md. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lifsey McCreedy</b>			

12-01033

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01094

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Jessie Lawler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-18-79</b>		2b. HOUR <b>7:00 P.M.</b>
3 SEX <b>female</b>	4 RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 8, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NYC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Arunah Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>ANNAPOLIS</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>12623 Beech Farm Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Burnett</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Farrell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-74-1974</b>		17. INFORMANT ADDRESS <b>Thomas Lawler same as 13e.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c) <b>Senile Change</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-18-79</b> , to <b>1-18-79</b> , that (I) (we) last saw the deceased alive on <b>1-18-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <b>Schue-Yuan Liao, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Schue-Yuan Liao, M.D.</b>		22e. ADDRESS <b>7600 Osler Med. Center, Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/22/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>East Hampton NY</b>
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>		ADDRESS <b>12 Ridgely Ave. Ann. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>L. H. Brady</b>	

MEDICAL CERTIFICATION

99

1

3 Mrs. Lawler  
Died on 1/18/79  
at 7 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

42010-87

STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

130-1-1-1  
Form 100-10  
100-10

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01095

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY A. Legge</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>79</b>		2b. HOUR <b>7:30 A</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>10</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>US Army</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>Vincent</b> MIDDLE <b>Legge</b> LAST <b>Nicolina</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Nicolina</b> MIDDLE <b>Trojan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 218-26-0406</b>		17. INFORMANT <b>Esther A. Legge</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>cardiogenic shock - pulmonary edema</b> (c) <b>myocardial infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/1/79</b> 19 <b>78</b> , to <b>11/1/79</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/1/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Angela C Healy MD</b>		DEGREE		22c. DATE SIGNED <b>11/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANGELA C HEALY MD</b>		22e. ADDRESS <b>BALTO CITY HOSP 4940 EASTERN AVE 21224</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore,</b>		COUNTY <b>Maryland</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. Healy</b>	



20010-02





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01096

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Milton N. Leininger			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1979		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3426 Bank Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergy - Presbyterian		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Emory Milton Leininger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Mantz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 186-09-1855		17. INFORMANT ADDRESS Rosalind Leininger, 3426 Bank Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic C.V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>53</u> , to <u>1/4</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>L.B. Stevens</u>		DEGREE MD		22c. DATE SIGNED 1/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L.B. Stevens MD		22e. ADDRESS 3400 Erdman Avenue Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-8-79		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
23d. LOCATION CITY OR TOWN Balto., Md.		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR JAN 8 1979		25b. REGISTRAR'S SIGNATURE <u>Rosmary McCreedy</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20010-02

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01097

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN LENNON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 22, 1979</b>			2b. HOUR <b>M</b>				
3 SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9/3/13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY of Baltimore</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2531 EDMONDSON AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>Rouse Co.</b>		
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2531 EDMONDSON AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Graham</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-03-5538</b>		17. INFORMANT ADDRESS <b>DELTHIE LENNON SAME</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> <b>several years</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/22</b> 19 <b>79</b> to <b>1/22</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>D. W. STEWART, M.D.</b>					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>1/23/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. W. STEWART, M.D.</b>					22e. ADDRESS <b>2300 Garrison Blvd</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>BAILEY F.H. 1348 CALHOUN ST.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Kelly</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

73-01097

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

LENNON

Back

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at 10:00 AM

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01098 REG. NO.									
1. FOR STATE REGISTRAR				2a. DATE OF DEATH				MONTH DAY YEAR				7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				MONTH DAY YEAR				7b. HOUR	
ADA LEVIN				01 14 79				1:25 A M					
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR		75		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA				BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		SINAI HOSPITAL				CLERICAL				FURNITURE STORE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		6968 MAR SUE DR. APT. 1A(21215)							
MARYLAND				BALTIMORE									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST			
LOUIS		FRIEDMAN		ROSE		SMALL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO				214-14-7487		HERSCHEL LEVIN 7408 BROMPTON RD. (21208)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- DUE TO, OR AS A CONSEQUENCE OF <u>S/P MYOCARDIAL INFARCTION</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> 19 <u>78</u> , to <u>1-14</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1-14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <u>Cesar G. Gamboa M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>												22c. DATE SIGNED <u>1-14-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CESAR G. GAMBOA, M.D.</u>												22e. ADDRESS <u>% SINAI HOSPITAL, BALTO.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				1/15/79		MOGAN ABRAHAM CONG.				ROSEDALE MD.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS.				6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				JAN 16 1979 <u>Anthony McCready</u>					

88010-02

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01099 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>MAURICE LEVINE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 13 79</b>	
3 SEX <b>M</b> MALE		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 14 98</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD.	
14 FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL LEVINE</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE <b>LOTTIE UNKNOWN</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>232-54-3673</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
17. INFORMANT ADDRESS <b>MRS. SIVERA LEVINE 4001 CLARKS</b>		17b. APT., APT. 403		17c. CITY, STATE, ZIP <b>#21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410- Anythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adult onset diabetes mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <b>1/12/79</b> , 19____, to <b>1/13/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/13/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE- <b>Martin Sheridan</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/13/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN SHERIDAN</b>		22e. ADDRESS <b>SINAI HOSP OF BALTO</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 15, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		24b. ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Henry Helms</b>					



ee010-ey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01100 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>EUGENE FORD LEWIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 26, 1979</b>			2b. HOUR <b>1:28 PM</b>		
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 05 08</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY OF MARYLAND HOSP.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NOT KNOWN</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Lansdowne</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>ALONZA Ford LEWIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Claudia Meekins MEEKINS</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-10-8918</b>		17 INFORMANT ADDRESS <b>NELLIE LEWIS, 214 Third Avenue 21227</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>410 -</b> conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE MYOCARDIAL INFARCTION &amp; PULMONARY EDEMA</b> ~ 12 hours ~ 3 days							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>HISTORY OF PREVIOUS MYOCARDIAL INFARCTION</b>								
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>January 26, 1979</b> , to <b>January 26, 1979</b> , that (we) (I) saw the deceased alive on <b>January 26, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Raymond H. Flores</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/26/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND H. FLORES</b>				22e. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.,</b>				ADDRESS <b>Balto., Md. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>		
				25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>				

53-01100

5-5-79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #586 Film G529 3/9/79 re		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH		79-01101	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Geraldine F. Lewis				1		15		79	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Black		1910		68		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Va.		USA				Baltimore City			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balto.		2631 W. Coldspring La.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.				Balto.				13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Luther		Perry		No		225-36-5999		Charles Lewis 3809 Parkview Ave.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410 -		myocardial infarction		coronary artery disease					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/19/79 to 1/19/79, that (I) (we) last saw the deceased alive on 1/19/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
P.S. WPHB M.D.						1/18/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
P.S. WPHB M.D.		5101 LANIER AVE BALTO., MD 21215		Burial		1/20/79		Mt. Zion Ch. Cem.	
24. FUNERAL DIRECTOR NAME		ADDRESS		24a. DATE RECD. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Wm C March F/H		1101 E. North Ave.		JAN 19 1979					

10110-25

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
30M 7/73

79-01102

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				79-01102 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <div>Virginia</div> <div>Lewis</div>				2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR <div>1</div> <div>10</div> <div>19 79</div>		2b. HOUR M <div>6:38P</div>	
3. SEX <div>Female</div>		4. RACE <div>Black</div>		5. DATE OF BIRTH MONTH DAY YEAR <div>2</div> <div>2</div> <div>13</div>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN <div>65</div> <div>YRS.</div>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <div>Virginia</div>		7b. CITIZEN OF WHAT COUNTRY? <div>U. S. A.</div>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <div>Baltimore City,</div> MD.	
10. CITY OR TOWN OF DEATH <div>Baltimore City</div>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <div>1508 N. Bradford Avenue</div>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <div></div>	
13a. STATE <div>Maryland</div>		13b. COUNTY <div></div>		13c. CITY OR TOWN <div>Baltimore</div>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <div>Joe</div> <div>Lewis</div>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <div>Ella</div> <div>Lewis</div>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <div></div>			
16b. SOCIAL SECURITY NO. <div>214-16-8795</div>		17. INFORMANT ADDRESS <div>Odessa Lewis 1508 Bradford Street</div>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div></div>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Mitral valvular disease</u>							
19a. DATE OF OPERATION <div></div>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <div></div>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <div></div>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <div></div> <div>P.M.</div> <div>19</div>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <div></div>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <div></div>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <div></div> <div></div> <div></div> <div></div>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .						Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion	
ACTUAL SIGNATURE <div>Virginia L. Dolan</div>		TITLE (SPECIFY) <div>Assistant</div>		M.D. MEDICAL EXAMINER		DATE SIGNED <div>1/12/79</div>	
EXAMINER'S NAME (TYPE OR PRINT) <div>Virginia L. Dolan, M.D.</div>		ADDRESS <div>111 Penn St. Balto., Md.</div>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <div>Burial</div>		23b. DATE <div>1/15/1979</div>		23c. NAME OF CEMETERY OR CREMATORY <div>Md. Nat. Mem. Park</div>		23d. LOCATION CITY OR TOWN COUNTY STATE <div>Laurel, Maryland</div>	
24. FUNERAL DIRECTOR NAME ADDRESS <div>Wm. C. March F/H 1101 East North Ave.</div>		25a. DATE REC'D. BY REGISTRAR <div>JAN 16 1979</div>		25b. REGISTRAR'S SIGNATURE <div>Tracy A. Chedy</div>			

28-01105



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01103			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Doris E. LIGHT. SEX</b>				2a. DATE OF DEATH MONTH DAY YEAR 1 28, 1979			
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR 7 26 1932		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joshua</b> <b>McRae</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel</b> <b>Cromartie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-28-3568</b>		17. INFORMANT ADDRESS <b>Guy Lightsey 1509 East 29th Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>Baerlar artery aneurysm - operat. o.</b> 4373 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>+ Brain edemat. + Vortex</b> (c) <b>Braintem compression due to Brain edemat.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION <b>1/19/79, 1/29/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Baerlar artery aneurysm + Brain edemat.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/14/79</b> , 19 <b>79</b> , to <b>1/28</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>D. Abon</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. ABASI HAFSHJANI</b>				22e. ADDRESS <b>Baltimore City Hospital 306 - 9234</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cromartie Hill Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clarkton, N. C.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Page 2 of 2

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for ensuring the integrity of the financial system and for providing a clear audit trail.

2. The second part of the document outlines the specific procedures that must be followed when recording transactions. It details the steps from initial entry to final review, ensuring that all necessary checks and balances are in place.

3. The third part of the document discusses the role of the accounting department in maintaining these records. It highlights the need for clear communication and collaboration between different departments to ensure that all transactions are properly recorded and reported.

4. The final part of the document provides a summary of the key points discussed and offers recommendations for improving the recording process. It stresses the importance of ongoing monitoring and evaluation to ensure that the system remains effective and efficient.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01104 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD C. LILLY</b>				2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>3</b> YEAR <b>1979</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>4</b> YEAR <b>1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alaska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home and Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seaman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>--</b> 13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <b>unk</b> MIDDLE <b>unk</b> LAST <b>unk</b>				15. MOTHER'S MAIDEN NAME FIRST <b>unk</b> MIDDLE <b>unk</b> LAST <b>unk</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>197-09-4072</b>		17. INFORMANT ADDRESS <b>242 S. Dallas Ct.</b> <b>Olive V. Dietz a/k/a Jean Lilly -21231</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>  DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF RECTUM</b>  DUE TO, OR AS A CONSEQUENCE OF (c) <b>1541</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>12-27-78</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INVASIVE VILLOUS ADENOMA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>78</b> , to <b>1-3</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1-3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>M. L. BILPURI</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. L. BILPURI, M.D.</b>				22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 9, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>-21202</b>	
24. FUNERAL DIRECTOR NAME <b>Henry Sander &amp; Sons, Inc. Balto., Md.</b> ADDRESS <b>-21213</b>				25a. DATE REC'D. BY REGISTRAR <b>10N 11 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

40110-25



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01105

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH 1	DAY 31	YEAR 79	2b. HOUR 9:30 A M
1. DECEASED NAME (TYPE OR PRINT)		FIRST RUDOLPH		MIDDLE LINDENMAN		LAST LINDENMAN	
3. SEX M Male	4. RACE W White	5. DATE OF BIRTH Sept 30 1922 XXX XXX XXX		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balt., Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Good Samaritan Hsp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical Engineer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE md		13b. COUNTY	13c. CITY OR TOWN Balt.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Balt., Md. 21214 5004 Grindon Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST August Lindeman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emilie Worze		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 215-09-7255		17. INFORMANT Wife: Amy B. Lindeman		ADDRESS Balt., Md. 21214 5004 Grindon Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 558- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Electrolyte Disturbances</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe malnutrition 2° to Chronic Diarrhoea</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Early Coronary Heart Failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-22-1979</u> to <u>1-31-1979</u> , that (I) (we) lost saw the deceased alive on <u>1-31-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George Kurian</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-31-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE KURIAN		22e. ADDRESS GOOD SAMARITAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 2 1979		23c. NAME OF CEMETERY OR CREMATORY Bay View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Jersey New Jersey	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 2 1979		25b. REGISTRAR'S SIGNATURE <u>Pitney Kelcey</u>	

Page 2 of 2

X

Washington, D.C.  
October 1, 1979

Mr. J. Edgar Hoover  
Federal Bureau of Investigation  
Washington, D.C. 20535

Dear Mr. Hoover:

I am writing to you regarding the

information that was provided to me

on October 1, 1979, regarding the

activities of the [redacted]

and the [redacted]

of the [redacted]

of the [redacted]

of the [redacted]

of the [redacted]

of the [redacted]

of the [redacted]

of the [redacted]

of the [redacted]

Very truly yours,

John Edgar Hoover

Director

Enclosure: 1. [redacted] 2. [redacted] 3. [redacted]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01106 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>HYMAN LINDER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1/22/79</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9-1-94</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		2b. HOUR <b>6:40 PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lithuania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>News dealer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>News</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>---</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Markowitz</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Goldberg</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b> <b>066-09-3389</b>		17. INFORMANT ADDRESS <b>Seymour Linder, 1902 Tadcaster Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC &amp; RESPIRATORY ARREST</b> <b>585-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC RENAL FAILURE, Congestive Heart Failure - 3 yrs.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/16/79</b> <b>more than</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> , 19 <b>79</b> , to <b>1/22</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. OSEI-WUSU</b>		22e. ADDRESS <b>St Agnes Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-24-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverside</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rochelle Park N. J.</b>
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg, Inc.</b>		ADDRESS <b>1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1979</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



79-01108

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01107  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>JAMES</b>		AKA <b>James Highsmith</b>		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR 1 - 1 19 79		2b. HOUR M 1:17	
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>39 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 1 - 1 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1317 S. Hanover Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1317 S. Hanover St.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Harry Mintz</b>		ADDRESS <b>1321 Hanover St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b> 303- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>H. S. Guard</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>1/2/79</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn St. Balto, MD Zip: 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-6-78</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>glen Burnie Md.</b>							
24. FUNERAL DIRECTOR NAME <b>William C. Brown</b>		ADDRESS <b>12-6-08 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 1 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. Kelly</b>							

70110-02



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01108 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) JOHN LIVANION						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 21, 1979			2b. HOUR 8:40 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 28, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6403 Alta Ave			
14. FATHER'S NAME FIRST MIDDLE LAST Mercourios Livanion				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Diamantia Skirioti							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO x		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-18-8661		17. INFORMANT Mrs Olga Livanion		ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 430- DO TO, OR AS A CONSEQUENCE OF (b) <u>EXTENSIVE SUBARACHNOID HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DO TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>1-19</u> , 19 <u>79</u> , to <u>1-21</u> , 19 <u>79</u> , that (1) <u>we</u> lost <u>saw</u> the deceased alive on <u>1-21</u> , 19 <u>79</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above; (2) <u>we</u> <u>did not</u> view the body after death.											
22b. SIGNATURE J. Bentram				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. BENTRAM, M.D.				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/79		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Leonard JRuck Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 23 1979		25b. REGISTRAR'S SIGNATURE Ricky McCreedy			

BP

80110-25



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH: 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01109

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		3a. MONTH		DAY		YEAR		2b. HOUR	
John		W				Lloyd		1		28		19		79		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
male	white	5/7/62		16 YRS.				1		28		19		79		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		BALTIMORE CITY OR COUNTY OF DEATH					
MD.		USA														Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital/ STU														RESTAURANT	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD.		BALTO		MIDDLE RIVER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		813 GLADWAY RD									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
DONALD W. LLOYD				BERNICE SHIEBECK													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
NO				CPR				PARENTS				ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries																	
8147																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
				2:05 PM 1 -28 19 79				pedestrian struck by automobile									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN					
				street				Middle River & Bird River Rds.				Essex, Balto Co MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				VIRGINIA L. DOLAN, M.D.				TITLE (SPECIFY)				DATE SIGNED					
								Assistant				1/28/79					
EXAMINER'S NAME (TYPE OR PRINT)				VIRGINIA L. DOLAN, M.D.				ADDRESS				111 Penn Street, Balto, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				1/31/79				GARDENS OF FAITH				BALTO. MD					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
J.B. CONNELLY				300 MACE				FEB 5 1979				Anthony McBrady					

23-01103



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01110	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE C. LOANE						2a. DATE OF DEATH MONTH DAY YEAR 1/29/79		2b. HOUR 8:05 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 2 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 704 St. George Rd. 21210			
14. FATHER'S NAME FIRST MIDDLE LAST C. GEROLL L. CARMINE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-32-5902D		17. INFORMANT ADDRESS E. Morgan Loane 5709 Roland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD (chronic obstructive lung disease)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHE (chronic congestive heart failure)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Histiocytic Lymphoma</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> 19 <u>78</u> , to <u>1/29</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daniel P. Conlin MD.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/29/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel P. Conlin MD				22e. ADDRESS UMH 201 E. Univ. Pkwy. Balt, Md. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/1979		23c. NAME OF CEMETERY OR CREMATORY David Ridge Mt		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Md					
24. FUNERAL DIRECTOR NAME (Print Name) Mitchell Wedgfeld				ADDRESS 6500 York Rd		25a. DATE REC'D. BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

01110-27

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01111  
REG. NO.FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN LOCUST</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/9/79</b>			2b. HOUR <b>11:30</b> M			
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/7/05</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unknown</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Manor N. H.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Md.</b>		13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1648 N. Smallwood St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>MOSES KING</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NANNIE WARREN</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-30-5249</b>		17 INFORMANT ADDRESS <b>Pleasant Manor Nursing Center 4615 Park Heights Ave., 21215</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>586- IUCMIA</b> IMMEDIATE CAUSE (a) <b>Wandering Sleepwalking</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Wandering Sleepwalking</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1970</b> , 19____, to <b>Jan 1979</b> , 19____, that (I) (we) last saw the deceased alive on <b>Dec 1978</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arbutus Arbutus</b> MDFAFP						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan 11/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARBUTUS MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>ARLINGTON S. PHILLIPS</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur McCreedy</b>	
ADDRESS <b>1721-27 N. MONROE ST.</b>									

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35  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11110-07

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DECEASED NAME (TYPE OR PRINT)										DATE KNOWN OF DEATH		2b. HOUR							
William Henry (Loften) Lofton										1 28 19 79		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		Black		11 12 32		46 YRS.						1 28 19 79		11:01A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina				U. S. A.								Baltimore City, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore City				2028 W. North Avenue															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2028 West North Avenue			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
Daniel Lofton						Dicley Taylor													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
Yes Korean						240-40-1049						Lillie Coles 2218 W. North Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Doxepin												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Acute propoxyphene intoxication																			
9503																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16 PART 1 OR PART 2)											
				P.M. 1/28/1979				self-ingested											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				Home				2028 W. North Ave. 3rd Fl. Baltimore Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Margarita A. Korell				M.D. Assistant				1/29/79											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Margarita A. Korell, M.D.				111 Penn St. Balto., MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				2/3/1979				Church Cemetery				Troy, North Carolina							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H				1101 East North Ave.				JAN 29 1979				Lillian K. Brady							

53-01115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.

STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				79-01113			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>ROCHEL E. LOGON</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-5-79</i>				2b. HOUR <i>8:05 A.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 22 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13e. STREET ADDRESS <i>3405 Walbrook Avenue</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Thomas</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Wise</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Rev. Mildred Fisher 3405 Walbrook Ave.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suspicion massive pulmonary embolism</i>											
5789 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Upper GI bleeding</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Young J. You</i>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/5/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>1/9/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arbutus, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 East North Ave.</i>				ADDRESS				25a. DATE REC'D. BY REGISTRAR <i>JAN 8 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreary</i>	



50-01113

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535



20% COLLEGE

BP \_\_\_\_\_  
DHMH - 16 50M 7/77  
(VRA 15(4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01114

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2:48 P.M.	
BRIAN CHRISTOPHER LONT		JANUARY 18, 1979			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR		IF UNDER 24 HRS	
		Dec. 7, 1978		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	ST. AGNES HOSPITAL		None		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Md	Anne Arundel	Edgewater	Edgewater, Md.	1713 Shadyside Dr.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Kenneth L. Lont		Ellen J. Brewer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Kenneth L. Lont, Same as 13 E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
<u>Multiple congenital anomalies</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JAN. 14, 1979</u> to <u>JAN. 18, 1979</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JAN. 18, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Bert E. Morton, M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BERT E. MORTON		BALTIMORE, MD., 21229 ST. AGNES HOSPITAL, 900 S CATON AV			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/20/79		Cedar Hill Cemetery	
24. FUNERAL DIRECTOR NAME		23d. LOCATION CITY OR TOWN COUNTY STATE		25a. DATE REC'D BY REGISTRAR	
Robert E. Wilhelm, Suitland, Md.		Suitland, Md.		JAN 23 1979	
				25b. REGISTRAR'S SIGNATURE	
				<u>[Signature]</u>	

79-01114

JANUARY 15, 1979

STAN CHRISTOPHERS

BALTIMORE CITY

BALTIMORE ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

XX

JAN 18 1979

X

X

XX

ST. AGNES HOSPITAL

BALTIMORE, MD. 21209

ST. AGNES HOSPITAL, 800 S. CATON AV

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01115

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Chester		B.				Lovick, Jr.		1		2		19 79	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
male	black	10 21 52		26 YRS.						1		2 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
N.C.		U.S.A.				Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		at home/126 Denison Street											
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		126 N. Dennison St.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Chester B. Lovick, Sr.				Ada Dancy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes				217-56-9232		Mr. Chester Lovick, Sr.		126 N. Dennison					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: Gunshot wound of head													
IMMEDIATE CAUSE (a) 9554													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				? P.M. 1 - 2 19 79				self inflicted					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
				home				126 Denison St. Balto City MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Thomas D. Smith				Assistant				1/3/79					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Thomas D. Smith, M.D.				111 Penn Street, Balto, MD 21200									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				1-8-79		Baltimore National				Baltimore			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
NAME Samuel T. Redd ADDRESS 5209 York Rd.				JAN 9 1979				[Signature]					

21110-01

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01116

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Drem NORWOOD Lowery			2a DATE OF DEATH MONTH DAY YEAR 01 23 79		2b HOUR 2140 <sup>M</sup>
3 SEX MALE	4 RACE W HITE	5. DATE OF BIRTH MONTH DAY YEAR AUG 31 1908	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BCHC at University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEALER		12b. KIND OF BUSINESS OR INDUSTRY SEAFOOD
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.	13c. CITY OR TOWN CALVERT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS OESTER HOUSE ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY CLAY LOWERY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET TYLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-01-2478		17. INFORMANT ADDRESS ANTONIA B. LOWER BROOME ISLAND, MD. 20615	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardio-respiratory arrest

Extensive lung heaf metastasis

Oat cell carcinoma of the lung

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joachim Fuks	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joachim Fuks	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN 27, 1979	23c. NAME OF CEMETERY OR CREMATORY SOUTHERN MEM. GARDENS	23d. LOCATION CITY OR TOWN COUNTY STATE DUNKIRK CALVERT MD.
24. FUNERAL DIRECTOR DONALD V. BORWARDT		25a. DATE REC'D. BY REGISTRAR JAN 29 1979	
ADDRESS PORT REPUBLIC, MD.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21110-02



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79-01117 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>Ida PESSIN LUBICH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 10 1979</b>				2b. HOUR <b>3:08 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 19, 1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2500 W. BELVEDERE AVE. #21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>NATHAN EVENTOFF</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RACHEL UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>20810 NORMAN PESSIN 9881 GORMAN RD., LAUREL, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Total Cardiorespiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Past History Of Cerebrovascular Accident</b>									
19a. DATE OF OPERATION <b>1-9-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Arterial Embolus To Right Leg</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>January 9</b> 19 <b>79</b> to <b>January 10</b> 19 <b>79</b> that <del>XX</del> (we) last saw the deceased alive on <b>January 10</b> 19 <b>79</b> and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (we) did <del>XX</del> view the body after death.									
22b. SIGNATURE <b>Krikor Tatoyan</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>1-10-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Krikor Tatoyan, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 11, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE NEISEN</b>		23d. LOCATION <b>ROSEDALE BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

71110-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01118	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Florence</b>				LAST <b>Lucas</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>-28</b> YEAR <b>79</b>		2b. HOUR <b>9:28</b> M	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>5</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3211 Serpentine Rd.</b>			
14. FATHER'S NAME FIRST <b>Sam</b> MIDDLE <b></b> LAST <b>Douglas</b>				15. MOTHER'S MAIDEN NAME FIRST <b></b> MIDDLE <b></b> LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>213-74-4708</b>		17. INFORMANT <b>Bernice Lynn</b> ADDRESS <b>3211 Serpentine Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rectal bleeding</b> (b) <b>probably due to cancer of colon</b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>1-24</b> , 19 <b>79</b> , to <b>1-28</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Hyung KIM, M.D.</b>				DEGREE <b></b>				22c. DATE SIGNED <b>1-28-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HYUNG KIM, M.D.</b>				22e. ADDRESS <b>2600 Liberty Heights Ave. Baltimore, Md 21215</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Arlington S. Phillips</b> ADDRESS <b>1721-27 N. Normal St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara McCready</b>					

81110-01

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01119

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alton O. Madkins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 2, 1979</i>		2b. HOUR M <i>AM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 2, 1972</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>66</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Foreman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Diamond Int. Truck</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN	13e. STREET ADDRESS <i>3726 Benson Ave. Arbutus, Md.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William ----- Madkins</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie ----- Woodland</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-09-9567</i>		17. INFORMANT ADDRESS <i>Mrs. Levita A. Madkins, Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASACVD, E. Congestive heart failure</i> <i>3500</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic 7 decompensation</i> <i>Renal insufficiency</i> (c) <i>Diabetes Mellitus</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-78</i> <i>10-78</i> <i>1973</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes ulcer L foot</i>					
19a. DATE OF OPERATION <i>1/2/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diabetes ulcer L foot</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/76</i> , 19____, to <i>1/2/79</i> , 19____, that (I) (we) lost saw the deceased alive on <i>12/17/78</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Karl Pass MD</i>		DEGREE		22c. DATE SIGNED <i>1/3/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. Epel MD</i>		22e. ADDRESS <i>4001 Wiehens Ave</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Jan. 3, 1979</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Security Process Crem. Inc. Baltimore, Maryland</i>		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 4 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Barbara McCreedy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91110-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01120 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lottie E. Mapp</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 2 79</b>		2b. HOUR <b>5:55a</b>			
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 26 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2104 Prestman Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph D. Nickers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>A</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>219-22-3448</b>		17. INFORMANT ADDRESS <b>Leon Nickers 719 North Monroe Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBROVASCULAR ACCIDENT</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>MYOCARDIAL INFARCTION AND HYPERTENSION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>RECTAL TUMOUR WITH BLEEDING, GENERALIZED ARTERIOSCLEROSIS</b>											
19a. DATE OF OPERATION <b>12/6/78</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RIGHT FEMORO POPLITEAL BYPASS</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/2</b> , 19 <b>78</b> , to <b>1/2</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Barth A. S. Samuels</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARTH A. S. SAMUELS</b>						22e. ADDRESS <b>6811 PARK HEIGHTS AVE, BALTIMORE MD 21215</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert H. Kelly</i>			



18-01150

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01121 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) ORVILLE T. MARSH						2a. DATE OF DEATH MONTH DAY YEAR 01 31 79				2b. HOUR 11:45AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 27 10		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 520 PARKSLEY AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN		12b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
13a. STATE MARYLAND				13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS SHIPBUILDING 520 PARKSLEY AVENUE, 21223	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE B. MARSH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDIE ANN TIBBOTT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 325-10-0371		17. INFORMANT ADDRESS HELEN V. MARSH, 520 PARKSLEY AVENUE, 21223					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mo.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-1-78</u> 19 <u>78</u> , to <u>1-31</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)											
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2-2-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HIROSHI NAKAZAWA, M.D.				22e. ADDRESS 3350 WILKENS AVENUE, BALTIMORE, MD. 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02-03-79		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND					
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR FEB 2 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

15110-05

10-1-73

FEB 3 1973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01122 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN STANLEY MARSHALL</b>				JANUARY 22, 1979 3:10 AM			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 7, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>62</b> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Ewell</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John C. Marshall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora Bradshaw</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		17. INFORMANT <b>Mary Ann Marshall</b>		ADDRESS <b>Same as 13 a,b,c,d,e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>4410</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HEMORRHAGE FROM CHEST TUBE + ENDOTRACHEAL TUBE SITES</b> DUE TO, OR AS A CONSEQUENCE OF (c) .							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>12/28/78/1/11/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AORTIC DISSECTION/TRACHEOSTOMY</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>12/27/78</b> to <b>1/22</b> , 19 <b>79</b> , that (1) we lost saw the deceased alive on <b>1/22</b> , 19 <b>79</b> , and that in (my) <b>hour</b> opinion death occurred on the date and hour and from the causes stated above, (1) we did not view the body after death.							
22b. SIGNATURE <b>M. Sweeney</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. SWEENEY MD</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTIMORE MD. 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ewell Methodist Cemetery Ewell Somerset Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Bradshaw &amp; Sons</b>				ADDRESS <b>Crisfield, Md. 21817</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

55-110-25

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01123

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Carrie MARTIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/20/79</b>			2b. HOUR <b>11:15am</b>				
3 SEX <b>F</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Richmond Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2728 Trolley Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Lee</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucinda Taylor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>229039380</b>		17. INFORMANT ADDRESS <b>Pauline Lee 1613 Northbourne Road</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Myocardial infarct**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**12/3/78****410-**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**Arteriosclerotic cardiovascular disease****severely**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Pulmonary embolism****disease****12/20/78**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/3/78</b> , 19 <b>78</b> , to <b>1/20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Amatur Moor Naem MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/20/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AMATUR MOOR NAEEM</b>				22e. ADDRESS <b>Lutheran Hospital 730 Ash</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/25/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Tom C. Moore</b>		1101 East North Ave.		25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McQuinn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



70-01153

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

RECEIVED  
FBI  
JAN 10 1964

100-441111

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100-441111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#6 8528 2/15/79 83		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 79-01124	
1. DECEASED NAME (TYPE OR PRINT) Emma (Martin) Martin		2a. DATE OF DEATH MONTH DAY YEAR 1-15-79		2b. HOUR 40 10p M	
3 SEX Female	4 RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 10 5 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Med. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY AD	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Butler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Nellie Williams 99 Cherry Lane	
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac episode 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years "
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Brain Syndrome					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 1/15 19 79 to 1/15 19 79, that (we) lost saw the deceased alive on 1/15 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Raymond Gladys M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/16/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/79	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 19 1979	

78-01154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01125	
1. FOR STATE REGISTRAR					
1. DECEASED NAME FIRST MIDDLE LAST Kathryn E Martin			2a. DATE OF DEATH MONTH DAY YEAR 1 20 79		2b. HOUR 8:40 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 11 11	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Oil Company
13a. STATE Md			13b. COUNTY Balt	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Frieser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Gahn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-07-9275		17. INFORMANT ADDRESS Joseph Martin, husband Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 1749 Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Pericardial Effusion DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Breast Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks 8 wks 5-20 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 12/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pericardial Obstruction		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 1976 to Jan 1979, that (I) (we) lost saw the deceased alive on Jan 20 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Janice P. Dutcher MD				22c. DATE SIGNED 1-20-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janice P. Dutcher MD				22e. ADDRESS BERC, Univ. of Md Hosp	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gard, Harford County, Maryland	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR JAN 25 1979		25b. REGISTRAR'S SIGNATURE P. H. H. H. H.	

23-01152

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **79-01126**

1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THERESA C. MARTIN (WASH)</b>				<b>JANUARY 18 1979</b>				<b>5:45PM</b>			
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-25-1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTO.</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
13a. STATE <b>MD.</b>				13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>507 N. MILTON AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK HERCULE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY SMITH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>218-44-2951</b>		17. INFORMANT ADDRESS <b>Mr. Richard R. Lindinsky 203 E. MONROE ST.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>2000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diffuse Histiocytic Lymphoma</b> (c) <b>3mo</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>October 19 78</b> , to <b>January 18, 1979</b> , that (1) (we) lost saw the deceased alive on <b>Jan 18</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.											
22b. SIGNATURE <b>Paul D. Scanlon</b>				DEGREE <b>MD.</b>				22c. DATE SIGNED <b>1/18/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul D. Scanlon</b>				22e. ADDRESS <b>Johns Hopkins Hospital Dept of Med</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1-22-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART OF JEWS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Barth Miller</b>				ADDRESS <b>2334 Jefferson St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Kelly</b>			

22-01128



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. <b>79-01127</b>				
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM BENJAMIN MARTIN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 18 1979</b>			2b. HOUR <b>9:45 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 31 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECURITY GUARD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POWERCON INC.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>303 EDWARD AVENUE, 21090</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>LINTHICUM</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN MARTIN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIRGINIA KATHERINE CLARK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-07-8953</b>		17. INFORMANT ADDRESS <b>ALVINA E. MARTIN, 303 EDWARD AVENUE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>3949</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CEREBRAL ANOXIA</b>									
19a. DATE OF OPERATION <b>1/10/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MITRAL VALVE DISEASE</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>1/8</b> 19 <b>79</b> , to <b>1/18</b> 19 <b>79</b> , that (1) <b>(we)</b> last saw the deceased alive <b>1/18</b> 19 <b>79</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>(we)</b> did <b>(do)</b> view the body after death.									
22b. SIGNATURE <b>Michael Sweeney</b>				DEGREE <b>MD</b>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL SWEENEY</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSP. BALTIMORE MD. 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>01-22-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McRuddy</b>			



12-01151

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#5, Film G528, 2/2/79 kam  
FOR STATE REGISTRAR  
Item #18a Film G530  
1/3/79 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01128

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Richard		E.		Mason		JR.		ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR		1 24 19 79	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR		2e. MIN.	
Male	White	10-10-1934	48 YRS.	MONTH DAY YEAR	MONTHS DAYS HOURS MIN.	1 24 19 79		12:05		PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		4007 Eierman Avenue		WATER DEPT.		CITY					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
MD		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4007 Eierman Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
RICHARD E. MASON, SR.		ELIZABETH E. SHELTERS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS					
YES		KOREAN		213-28-3523		Mr. Raymond E. Mason - 5225 Darian Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18a. IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF		18c. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Acute Peritonitis		Pancreatitis with peritonitis									
5679											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Virginia L. Dolan		Assistant		1/25/79							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Virginia L. Dolan, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		1-27-79		PARKWOOD CEMETERY		BALTO. MD					
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HARRY WILSON		7527 Hanford Rd.		JAN 26 1979		Harry Wilson					

10-01158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01129

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Theodore				MAULL	January 8 1979				4:20A M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	BLACK	3 MONTH 4 DAY 29 YEAR		49 YRS	MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE	US			Baltimore City MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Maryland General Hospital		PROFESSOR						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
MARYLAND				BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1014 ARGONNE DRIVE			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
JOSEPH		CHRISTINE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
YES		KOREAN		JOSEPH REDDING 2115 N. LOCUST ST., DELAWARE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Oat Cell Carcinoma Of Lung, Metastatic</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								1 Year	
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (we) (this hospital) attended the deceased from <u>January 7</u> , 19 <u>79</u> , to <u>January 8</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 8</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Michael J. Quinn		M.D.						1-8-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Michael J. Quinn, M.D.		c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		1-12-79		SILVERBROOK CEMT.		WILMINGTON		DELAWARE	
24 FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ARLINGTON S. PHILLIPS		1721-27 N. MONROE ST.				JAN 16 1979		L. J. McCurdy	

BP

52-01153

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01130

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Walter I. MAZAN			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1979			2b. HOUR 8:25 PM				
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7-28-12		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.				
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME & HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY NEWARK		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18 S. CHESTER ST	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB MAZAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 29-30-9782	
17. INFORMANT ADDRESS 18 S. CHESTER			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 410 - DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Brain Damage Secondary to Cardiorespiratory			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Arrest										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 11, 1979, to Jan 19, 1979, that (I) (we) last saw the deceased alive on Jan 11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE G. Karkar M. D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1-19-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Karkar M. D.			22e. ADDRESS 100 N. Broadway							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-23-79		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR NAME JOHN M. WEBER			ADDRESS S. CHESTER		25a. DATE REC'D. BY REGISTRAR JAN 25 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-01130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01131 REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JULIA B. MCABEE		2a. DATE OF DEATH MONTH DAY YEAR 11/5/79		2b. HOUR 3am	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec.		12b. KIND OF BUSINESS OR INDUSTRY Civil Serv.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST James D. Brady				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 414-09-6948		17. INFORMANT (Daughter) ADDRESS Mrs. Mary Mc Abee Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia (aspiration) + hyperthermia = fever</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Symptoma - haemorrhagic</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/10/78 July 1978	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/18/78</u> , 19____, to <u>4/5/79</u> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen M. Doben</u>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN M. DOBEN M.D.				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/79		23c. NAME OF CEMETERY OR CREMATORY Mem. Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Memphis Shelby Tenn.			
24. FUNERAL DIRECTOR Fleming Funeral Service				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

18110-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01132 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST <del>XXXXXXXX</del> Ethel L. M <sup>C</sup> Cauley				January 5, 1979 97:40 PM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10-09-99		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY *		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Bowersox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Stevens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218 22 1548B		17. INFORMANT ADDRESS Herbert W. Mc Cauley 3533 Falls Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4092 DUE TO, OR AS A CONSEQUENCE OF: (b) ASCVD/XXXXXXXXXXXX Atrial Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c) Septicemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/Dec. 7</u> , 19 <u>79</u> , to <u>Jan. 5</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 5</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>K George Thomas</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. K George Thomas		22e. ADDRESS Church Hospital Corp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/9/79		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto Md	
24. FUNERAL DIRECTOR Burgee Funeral Home 3631 Falls Road 21211				25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>	

79-01132

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01133  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ERNEST S. McCLEARY</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>79</b>			2b. HOUR M					
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>4</b> YEAR <b>89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Edgewood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lithographer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Barton- Cotton</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1000 E. Joppa Road</b>			
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>R.</b> LAST <b>Mc Cleary</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Storey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-07-6912A</b>		17. INFORMANT <b>Elizabeth M. Shoemaker, Same As #13e</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4912</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure, secondary to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Chronic bronchitis, Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic bronchitis, Emphysema</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Anemia - transient ischemic attack - Left CVA (Cerebral Vascular accident)</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 5 - 25</b> 19 <b>78</b> , to <b>Jan 1</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 29</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Manuel Sodaro</b> MD						DEGREE <b>MD</b>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Manuel Sodaro MD</b>						22e. ADDRESS <b>4624 York Rd - 21212</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New London Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>New London, Pennsylvania</b>					
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>				ADDRESS <b>1050 York Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McCready</b>			

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33-01133





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01134  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
DAISY BROWN McCLELLAN		FEMALE		BLACK	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MAY 30, 1905		73 YRS.		A.A. CO., MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		BALTIMORE CITY MD.		BALTIMORE	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PROVIDENT HOSPITAL		UNEMPLOYED			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND				BALTIMORE	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
MONROE		SARAH		NO.	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF	
219-32-4078		DELMA BARNES 3412 FAIRVIEW ROAD		Cardiopulmonary Arrest	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/12/79, to 11/13/79, that (I) (we) last saw the deceased alive on 11/12/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
[Signature]		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		11/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
OPHELIA LOOT, MD		PROVIDENT HOSPITAL, LIBERTY HEIGHTS AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		1-17-79		ARBUTUS MEM. PK.	
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
LEROY D. DYETT		4600 LIBERTY HTS. AVE.		JAN 17 1979	
				25b. REGISTRAR'S SIGNATURE	
				[Signature]	

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43110-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01135 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DENVER GALE MC CLURE, Sr.						2a. DATE OF DEATH MONTH DAY YEAR 1 9 79		2b. HOUR 2:10P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 30 44		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Junk			
13a. STATE PA.		13b. COUNTY York		13c. CITY OR TOWN Delta		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 1 DELTA, PA. 17314			
14. FATHER'S NAME FIRST MIDDLE LAST Rex McCleure		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Turner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) VIETNAM		211-34-8729		17. INFORMANT ADDRESS Glenn McClure, Conowingo, Maryland 21918					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>exsanguination from acute upper g.i. bleed</u> 5713 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>end stage alcoholic liver disease</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>DECEMBER 22, 1978</u> , to <u>JANUARY 9, 1979</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JANUARY 9, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <u>Stu Zipper MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/9/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stu ZIPPER MD</u>		22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD. 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/1979		23c. NAME OF CEMETERY OR CREMATORY Stewartstown Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stewartstown, York, Penna.					
24. FUNERAL DIRECTOR NAME <u>Kenneth W. Osburn</u>		ADDRESS Stewartstown, Penna.		25a. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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28-01132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01136 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James Ross McCOMAS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 20, 1979</b>		2b. HOUR <b>12:30 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 3, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3601 Greenway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pharmacist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Emp.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3601 Greenway</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Ross McComas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Virginia Livingston</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-01-1255</b>		17. INFORMANT ADDRESS <b>Mrs. J. Raymond Grant Bel Air, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis.</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>74</b> , to <b>1/20</b> , 19 <b>79</b> , that (I) <del>lost</del> saw the deceased alive on <b>10/17</b> , 19 <b>74</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do</del> (did) <del>not</del> view the body after death.											
27b. SIGNATURE <b>Norman L. Freeman, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <b>1/22/79</b>			
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Norman Freeman, M.D.</b>						27e. ADDRESS <b>11 W. 29th Street Balto., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Pitney Melvody</b>			
ADDRESS <b>4905 York Road Balto., Md. 21212</b>											

8E110-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01137 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) THEODORE A. MC COY, Sr.					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1979			2b. HOUR P 3:45 M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 8 4 1923		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1406 Edison Highway			
14. FATHER'S NAME FIRST MIDDLE LAST Herbert McCoy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie McCoy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 216-16-1414		17. INFORMANT ADDRESS Richard McCoy 1406 Edison Highway							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hepatic &amp; renal failure (hepato-renal syndrome)</i> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic anaplastic carcinoma of pancreas</i> 3-4 months DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 12/21/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED obstructive jaundice				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>December 1, 1978</i> to <i>January 1, 1979</i> , that (I) (we) last saw the deceased alive on <i>January 1, 1979</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) sew the body after death.											
22b. SIGNATURE <i>Jonathan Greenberg</i> MD				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan Greenberg MD				22e. ADDRESS Johns Hopkins Hospital Baltimore, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/6/1979		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.				ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 3 1979		25b. REGISTRAR'S SIGNATURE <i>Lester K. Kuhn</i>			



78110-25

Handwritten signature and date: 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01138 REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Palmer Mc Craw</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>1-24-1979</i>			2b. HOUR <i>5<sup>25</sup> A M</i>		
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 17 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deaton Medical Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Meat Cutter</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Md.</i>						13b. COUNTY		13c. CITY OR TOWN <i>City</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Will McCraw</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Percilla Peoples</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis 70</i> <i>185-</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Infected Decubiti</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Ce of prostate &amp; ureth.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Renal failure, chronic</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <i>1/24/79</i> to <i>1/24/79</i> , that (we) lost <i>1/24/79</i> above (we) did (not) view the body after death.											
22b. SIGNATURE <i>J. Raymond Gladen</i>						DEGREE <i>MD</i>			22c. DATE SIGNED <i>1/24/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Raymond Gladen</i>						22e. ADDRESS <i>611 S. Charles Street</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>1-27-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Western Star Cem</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Isaiah L Brown &amp; Son</i>						ADDRESS <i>PA 1913 W. Baltimore St.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 24 1979</i>		
						25b. REGISTRAR'S SIGNATURE <i>Petrykel</i>					

8E110-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove cornea, eyes, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

#1 8521 1/50/79 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01139  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
FRANCIS H. McCully JR.		Male		White		December 13 1934	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7a. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		THE JOHNS HOPKINS HOSPITAL		District Manager		Sales	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Pikesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Frank H. McCully Sr.		Kathleen R. Mooney		Yes		Korean 216-30-1519	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?	
Wife: Joanne E. McCully		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Renal Failure				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ADDRESS Pikesville, Md. 701 Carysbrook Road		DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
Peripheral Vascular Disease, Thrombocytopenia, Infection, Leukopenia				P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Dan L. Silverberg MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
SILVERBERG		JOHNS HOPKINS HOSPITAL		Burial		Jan 31 1979	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Moreland Memorial		Baltimore Maryland		Leonard J. Ruck, Inc. Baltimore Maryland		JAN 29 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE					

BP

72-01132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01140 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>Larry</b> <b>McFadden</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>18</b> YEAR <b>79</b>		2b. HOUR <b>4:10</b> AM	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>16</b> YEAR <b>17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home &amp; Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8 Exeter St.</b>	
14. FATHER'S NAME FIRST <b>Warren</b> MIDDLE <b>McFadden</b> LAST <b>McFadden</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Mae</b> LAST <b>Mae</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-03-1118</b>		17. INFORMANT ADDRESS <b>Larry McFadden 213 N. Duncan St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.V.A. (Brain Infarct)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> 4349							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-28-</b> 19 <b>78</b> , to <b>1-18-</b> 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>1-18-79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <b>Barry Kuppumony MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/18/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barry Kuppumony</b>		22e. ADDRESS <b>Church Hosp.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE <b>JAN 22 1979</b>			

79-01140



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01141 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) BETTY Ellen MCGINLEY				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23 1979			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Burgen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A			
16b. SOCIAL SECURITY NO. 213-20-7479		17. INFORMANT ( wife ) ADDRESS Mr. James R. McGinley		17. Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Andrew Cohen</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-23-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Cohen				22e. ADDRESS 4940 Eastern Ave Balt.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/79		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME R. N. Hopkins Singleton Funeral Home				ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR JAN 24 1979	
				25b. REGISTRAR'S SIGNATURE <u>Patrick McCready</u>			



14110-05

Female	White	Nov. 12, 1957	57
Married	U.S.A.		
Baltimore	John & Alice	Housewife	Own home
Maryland	John & Alice	704 Castle Road	
Henry	Burton	Mary	UNKNOWN
NO	213-20-7-70	Mr. James R. McKinley	213

Butler 1/26/73 Jane V. Mc. R. Zerkville Carroll Md.  
Singer General Home 1 Second, No. 151 1/2 St. N. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01142  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CARLOS Theodore McGOWAN			2a DATE OF DEATH MONTH DAY YEAR 1/21/79			2b HOUR 5:45 PM			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 9 27 23		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD			
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD. HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILL OPERATOR CEMENT MFG		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE M.D. 13b COUNTY WASHINGTON 13c CITY OR TOWN HAGERSTOWN					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 910 GUILFORD AVE.		
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELsie McGOWAN				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. WWII 215-18-1874		17 INFORMANT NORMA K. McGOWAN		ADDRESS 910 GUILFORD AVE HAGERSTOWN, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) fever, hypotension - ? septic shock ? 2050 } DUE TO, OR AS A CONSEQUENCE OF (b) Acute myelomonocytic leukemia DUE TO, OR AS A CONSEQUENCE OF (c) } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from DEC. 5, 1978, to JAN. 21, 1979, that (I) (we) lost saw the deceased alive on JAN 21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Joan M. Bathon M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 1/21/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joan M. Bathon, M.D.					22e ADDRESS UNIV OF MD. HOSPITAL				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 1-24-79		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.		
24 FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc. Hagerstown, Md.					25a DATE REC'D. BY REGISTRAR JAN 26 1979		25b REGISTRAR'S SIGNATURE Ruthy McCreedy		

78-01145

NOT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01143

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN ESTI- MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. HOUR	
John		E.		McGrady				1 31 19 79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.	
Male		White		July 3, 1916		62 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		U.S.A.		WIDOWED		DIVORCED		Baltimore City, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore City		Bon Secour Hospital		Mechanic		Truck Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.				Baltimore		YES NO		2125 McHenry St. 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Richard		Ora		?		233-14-3009		Miss Beatrice McGrady (as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART I DEATH WAS CAUSED BY:		20. PARTIAL		21. PARTIAL		22. PARTIAL	
5718		Fatty liver		YES X NO		YES X NO		YES X NO	
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF					
		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. PARTIAL		21. PARTIAL	
						YES X NO		YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		WHILE AT WORK NOT WHILE AT WORK		CITY OR TOWN COUNTY STATE	
		P.M. 19							
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion	
death resulted from:		Natural causes		Accident		Suicide		Homicide	
		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		1/31/79			
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		Deputy Chief		MEDICAL EXAMINER			
ADDRESS		111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		2/3/1979		Crest Lawn		Sykesville, Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
G. Truman Schwab		3512 Frederick Ave.		FEB 7 1979		R. H. McCreedy			

84110-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01144 REG. NO.			
1- STATE REGISTRAR										2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur B. McKewin										KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR 1 13 19 79		M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1892		6. AGE (IN YEARS) (LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 13 19 79		2d. HOUR 8:30P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent Balto. Gas&Elec.				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3501 St. Paul Street					
14. FATHER'S NAME FIRST MIDDLE LAST John Henry McKewen						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret C. UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-05-6595		17. INFORMANT ADDRESS John Leo McKewen Timonium, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries with complications</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 2 P.M. 12 8 19 78				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3500 Blk. St. Paul St. Balto MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>						TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER						DATE SIGNED 1/14/79	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.						ADDRESS 111 Penn St. Balto. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 17, 1979		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Rick Towson Funeral Home, Inc. Towson, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 16 1979				25b. REGISTRAR'S SIGNATURE <i>Jeffrey Helms</i>			

MEDICAL CERTIFICATION

44110-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01145 REG. NO.	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Thomas P. McLaughlin</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>January 23 1979</i>			2b. HOUR <i>10:45AM</i>		
3 SEX <i>Male</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Dec. 7 1915</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Welding Engr.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Engr.</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Baithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>15216 Apricot Lane</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas P. Dunn</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Brown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>087-10-5879</i>		17. INFORMANT ADDRESS <i>Michelle Clarke (same as 13e)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alveolar Cell Carcinoma Of The Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Suspected Thrombosis Right Iliac Artery</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>January 2</i> 19 <i>79</i> , to <i>January 23</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>January 23</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Arthur A. Serpick</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>1-23-79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur A. Serpick, M.D.</i>				22e. ADDRESS <i>1114 St. Paul Street 21202 Baltimore, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>1-25-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Fairfax Va.</i>					
24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY FUNERAL HOMES P/A</i>				ADDRESS <i>ROCKVILLE MD.</i>		25a. DATE RECEIVED BY REGISTRAR <i>FEB 1 1979</i>					
25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>											

24110-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01146	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN A McMULLEN						2a. DATE OF DEATH MONTH DAY YEAR JAN 15 79		2b. HOUR 4:50 PM	
3 SEX M.		4 RACE W.		5. DATE OF BIRTH MONTH DAY YEAR Dec 26 76		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JUN PAPER		12b. KIND OF BUSINESS OR INDUSTRY —			
13a. STATE md		13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5003 HILLEN RD			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA WELTZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) —		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS CARLYN 5003 HILLEN RD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GI Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) CA of Pancreas. DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1-16-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of pancreas + GI Bleeding				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-19, 1978, to 1-15, 1979, that (I) (we) lost saw the deceased alive on 1-15-79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jorge Pontilla				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-15-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge Pontilla				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. Bleemann		6067 Hayford Rd		JAN 23 1979		H. H. H. H. H.					

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8184 63 56  
FOR  
NANCY, NANCY  
REGISTRAR  
02-16STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01147  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>NANCY</b>		FIRST <b>L.</b>		MIDDLE <b>MCNUITY</b>		LAST <b>MCNUITY</b>		2a DATE OF DEATH MONTH DAY YEAR <b>JAN 30, 1979</b>		2b HOUR <b>1:05</b>		P <b>M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Feb. 12, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		7a IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		7b IF UNDER 24 HRS HOURS MIN <b>YRS</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a STATE <b>New York</b>				13b COUNTY		13c CITY OR TOWN <b>Poughkeepsie</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>55 Crestwood Blvd.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Lynch</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Braughagen</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>072-10-8710</b>		17 INFORMANT ADDRESS <b>Robert G. Urch, Jr. 1006 Bosley Road 21030</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF b) <b>METASTATIC SQUAMOUS CELL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>JAN. 30</b> , 19 <b>79</b> , to <b>JAN. 30</b> , 19 <b>1979</b> that (I) (we) lost saw the deceased alive on <b>JAN. 30</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <b>Michael Lieppman MD</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>1/30/79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL LIEPPMAN</b>				22e ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>2-3-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>				23d LOCATION CITY OR TOWN COUNTY STATE <b>Poughkeepsie, New York</b>			
24 FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 212</b>						25a DATE REC'D. BY REGISTRAR <b>FEB 2 1979</b>		25b REGISTRAR'S SIGNATURE <b>Pitney Hardy</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

58-01115

8 194 63 20  
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03-15-70

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-01148							
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> (JOHNNY) <sup>MIDDLE</sup> John <sup>LAST</sup> E. MCRAE										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <sup>DAY</sup> 1 <sup>YEAR</sup> 7 19 79		2b. HOUR <sup>M</sup> 10:45 <sup>A</sup> M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH <sup>MONTH</sup> 4 <sup>DAY</sup> 14 <sup>YEAR</sup> 00		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <sup>MONTH</sup> 1 <sup>DAY</sup> 7 <sup>YEAR</sup> 19 79		10:45 A M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 833 Whitelock Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland										13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 833 Whitelock Street	
14. FATHER'S NAME <sup>FIRST</sup> Elliot <sup>MIDDLE</sup> <sup>LAST</sup> McRae					15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Lila <sup>MIDDLE</sup> <sup>LAST</sup> McRae												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WWII				17. INFORMANT Mary McRae				ADDRESS 833 Whitelock Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Margie A. Korell</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 1/8/79					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/13/79		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Red Springs, N. C.							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.						25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE <i>Patricia Helms</i>									



84110-02

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHREG. NO. **79-01149**  
DATE OF DEATH MONTH DAY YEAR HOUR  
**1 6 79 10:15 PM**

1. FOR STATE REGISTRAR		DECEASED NAME FIRST MIDDLE LAST <b>CARRIE NMN MC SHANE</b>		DATE OF DEATH MONTH DAY YEAR HOUR <b>1 6 79 10:15 PM</b>	
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 31 1896</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>29 S. PROSPECT AVE.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN SCHEUCH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-14-7257</b>	17. INFORMANT ADDRESS <b>JOE D. McSHANE SAME. 21220</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis &amp; CARDIOGENIC Shock.</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION PNEUMONITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RECENT CEREBROVASCULAR ACCIDENT</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Severe ASCVD.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 6 1979</b> to <b>JAN 6 1979</b> , that (I) (we) last saw the deceased alive on <b>JAN 6 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>—</b>		22c. DATE SIGNED <b>1-6-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. N. MACHIRAN</b>		22e. ADDRESS <b>4713 Leeds Ave, ARBUTHNOT, 21227</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1-10-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WOODBURN PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FARLEY F.H.</b>		ADDRESS <b>6601 FRED. AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

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9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

79-01149

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

WILKINSON

SCHEMCH

JOHN

PROVIDENT 321 D. M. 214

NO

ST. AGNES HOSPITAL

WILKINSON

SCHEMCH

JOHN

PROVIDENT 321 D. M. 214

ST. AGNES HOSPITAL

WILKINSON

SCHEMCH

JOHN

PROVIDENT 321 D. M. 214

ST. AGNES HOSPITAL

WILKINSON

Items #10-22a Film G529 3/6/79 re  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01150

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
Johnnie		McWilliams						1		28		19		79		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	1 23 11 68		18 YRS.						1		28		19		79	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				10:00 a. M.	
MD.		U.S.										Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		at home/ 5 N. Exter Street															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD.		BALTO		BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5 N. Exter St.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Daniel McWilliams		Flori Hayden															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
(YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		215-01-7626		Helen Taylor		5 N. Exter St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
402-				DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		Virginia L. Dolan		M.D.		Assistant		DATE SIGNED		1/28/79							
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street, Balto, MD 21201											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		2-2-79		Mt. Calvary		Balto. Md.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
William Wright		FEB 1 1979		Rickey K. Kline													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01151  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMANUEL MEHR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 12 79</b>			12. HOUR A <b>0012 M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 13 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MARYLAND HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COMPUTER SCIENTIST</b>		12b. <del>COMPUTERS</del> <del>XXXXXXXXXX</del>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>NEW YORK</b>		13b. COUNTY <b>XXXXXXXX</b>		13c. <b>XXXXXXXX</b>		13d. <b>XXXXXXXX</b>		13e. STREET ADDRESS <b>801 MAGNOLIA DR.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY MEHR</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REBECCA UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES UNK.</b>					
16b. SOCIAL SECURITY NO. <b>WWII-NAVY</b>		17. INFORMANT <b>MRS. VARDA SIEGLER</b> <b>666 HARLESS PL. W. HAMPSTEAD, NY 11552</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACEREBRAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>THROMBOCYTOPENIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE MYELOMONOCYTIC LEUKEMIA</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2+ months</b> <b>4 months</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>SEPT 28</b> , 19 <b>78</b> , to <b>12 JAN</b> , 19 <b>79</b> , that (I) <del>was</del> lost saw the deceased alive on <b>11 JAN</b> , 19 <b>79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>John L. Foy</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/12/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN L. FOY</b>			22e. ADDRESS <b>BALTIMORE CANCER RESEARCH CENTER</b> <b>UNIVERSITY OF MARYLAND HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>			23b. DATE <b>JAN. 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW MONTEFIORE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>NEW YORK NEW YORK</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>					25a. DATE FILED BY REGISTRAR <b>JAN 16 1979</b>		25b. <del>REGISTERED</del> <b>History/History</b>		

BP

12110-07





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. 2. AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
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30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. <b>79-01152</b>		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence E. Meldron</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH DAY YEAR <b>1 11 19 79</b>		2b. HOUR <b>9:45 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-10-28</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>50</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 11 19 79</b>		2d. HOUR <b>9:45 AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sandblaster</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1915 Belmont Terr. 21207</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Raymond Meldron</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnas ? ?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>1951-1956</b>		17. INFORMANT ADDRESS <b>Eileen Gibson 1915 Belmont Terr. 21207</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Head Injury</b> <b>8811</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:15 AM 1 11 19 79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject fell from scaffold</b>						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>school grounds</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3910 Barrington Rd., Baltimore Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			M.D. <b>Assistant</b>			MEDICAL EXAMINER			DATE SIGNED <b>1/11/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-15-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Stansbury Funeral Home 6411 Windsor Mill Rd.</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>JAN 16 1979</b>				

MEDICAL CERTIFICATION

18-01125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01153	
1. FOR STATE REGISTRAR					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stephen Joseph MELLINGER			2a. DATE OF DEATH MONTH DAY YEAR JAN 28 1979		2b. HOUR 1 15 AM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 7, 1978		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 6 21	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXX
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Millersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 389 Elm Road	
14. FATHER'S NAME FIRST MIDDLE LAST Richard D. Mellinger Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JoAnn L. Cirri		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. XXXXXXX none		17. INFORMANT ADDRESS same as 13 Mrs. JoAnn L. Mellinger (mother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 7597 DUE TO, OR AS A CONSEQUENCE OF (b). POSSIBLE SEPSIS / HYPO GLYCEMIA (c). MULTIPLE CONGENITAL ANOMALIES					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN 15 MIN BIRTH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from 7/7, 1978, to 1/28, 1979, that I (we) lost saw the deceased alive on 1/28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. M. Hachal MD		DEGREE		22c. DATE SIGNED 1/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. Hachal MD		22e. ADDRESS JH#			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 30, 79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Brooklyn, MA MD	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 30 1979	
25b. REGISTRAR'S SIGNATURE [Signature]					

13-01123

MULTIPLE (CONGENITAL) ANOMALIES  
POSSIBLE REASONS / ALSO POSSIBLE

X

CIC 2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01154

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 13 19 79										7b. HOUR M 4:00PM
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 13 19 79				7b. HOUR M 4:00PM
Gilbert		Melton										
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 27 41	6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 1 13 19 79						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3608 W. Garrison Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rail Receiver		12b. KIND OF BUSINESS OR INDUSTRY B. Green Co.				
13a. STATE Maryland												
13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3608 W. Garrison Avenue						
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Carney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Melton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 214-38-9046		17. INFORMANT Mrs. Ernestine Melton						
						ADDRESS 3608 Garrison						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOURS MIN MONTH DAY YEAR 3:45 P.M. 1 13 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot by police officer						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3608 W. Garrison Ave. Balto MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 1/14/79				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Powell F/H				ADDRESS 319 N. Schroeder Street				25a. DATE REC'D. BY REGISTRAR JAN 17 1979		25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <b>79-01155</b>		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) <b>GLADYS ELIZABETH METCALF</b>					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		MONTHS		DAYS		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat cutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>		HOURS		MIN		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5554 Gayland Road</b>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST <b>John C. Kaler</b>					FIRST MIDDLE LAST <b>Annie B. Esslinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>220-14-4116</b>		17. INFORMANT ADDRESS <b>Vernon C. Metcalf 3675 McJavish Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asystole</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral Pulmonary Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Uremic Sub Infection</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET						
22a. I certify that (I, this hospital) attended the deceased from <b>1-7-79</b> , to <b>1-11-79</b> , that (I) (we) last saw the deceased alive on <b>1-11-79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
<b>Dennis M. Smith</b>			<b>MD</b>						<b>1-11-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS M. SMITH MD</b>						22e. ADDRESS <b>St. Agnes Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home</b> ADDRESS <b>1328 Sulphur Spring Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



22110-02

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 79-01156

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 10 19 79										2b. HOUR 11:30a	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Howard		MIDDLE Bruce		LAST Metzger							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 3, 1957		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 1 10 19 79		11:30a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 28 E. Ostend Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. IN THE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1347 Jackson St. Balto. Md.					
14. FATHER'S NAME FIRST William		MIDDLE		LAST Metzger		15. MOTHER'S MAIDEN NAME FIRST Dorothy		MIDDLE		LAST Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Dorothy Metzger, Same as above		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u> 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR xx 1 10 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) hanged self									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) jail cell		21f. LOCATION STREET 28 E. Ostend St.		CITY OR TOWN Balto.		COUNTY		STATE Md.			
22a. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Thomas D. Smith		TITLE (SPECIFY) M.D. Deputy Chief		MEDICAL EXAMINER		DATE SIGNED 1/10/79							
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St.		Balto., Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 15, 1979		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN Glen Burnie, A.A.		COUNTY Co.		STATE Maryland			
24. FUNERAL DIRECTOR NAME McQuilly Funeral Home, 130 C. Fort Ave. Balto. Md.		25a. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE									

78-01126

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01157	
1. FOR REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John J. Meyer, Sr.						2a. DATE OF DEATH MONTH DAY YEAR January 26, 1979			2b. HOUR 8:25 PM		
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4/8/22		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 56 56		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Emergency Room				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Md						13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Peter J. Mayer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth C. Kocher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-18-6443		17. INFORMANT ADDRESS Margaret Meyer/2608 W Patapsco Ave/21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration</u> 1990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bert F. Morton, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-27-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bert F. Morton, MD						22e. ADDRESS ST. Agnes Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 01/31/79		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland			
24. FUNERAL DIRECTOR NAME Walters Funeral Home/Pratt & Stricker Streets						25a. DATE REC'D. BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE			

22110-02

22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01158  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELISABETH ELIZABETH</b>		MIDDLE <b>MEYERS</b>		LAST <b>MEYERS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 17 1979</b>				2b. HOUR <b>12:10A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-14-03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Germany</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1634 N. Bradford St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emile Truss</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-74-6828</b>		17. INFORMANT ADDRESS <b>John E. Meyers, 1634 N. Bradford St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALNUTRITION / CACHEXIA</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> 19 <b>79</b> , to <b>1/17</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/16</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>JO Brennan</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/17</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JO BRENNAN</b>				22e. ADDRESS <b>JOHNS HOPKINS</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1-18-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

0802

82110-05

UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315

100-100000

1. NAME	2. GRADE	3. POSITION	4. ORGANIZATION
JOHN H. JONES	MAJOR	CHIEF OF BATTALION	1ST INFANTRY DIVISION
1. ADDRESS	2. CITY	3. STATE	4. ZIP CODE
1234 MAIN STREET	WASHINGTON	DC	20315
1. PHONE NUMBER	2. TELETYPE	3. RADIO	4. FAX
123-4567			
1. DATE	2. TIME	3. DAY	4. MONTH
10/10/70	10:00	10	10
1. SIGNATURE	2. NAME	3. GRADE	4. POSITION
[Signature]	JOHN H. JONES	MAJOR	CHIEF OF BATTALION

100-100000



100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01159  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eleanor A MICHELS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 25 1979</b>			2b. HOUR <b>7:05P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 30 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Stewarts</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5800 Oak View Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herman J. Michels</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Eifert</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-07-5171</b>		17. INFORMANT ADDRESS <b>Hilda Mc Donagh 7 Asguard Court</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus - Saddle Type</b> <b>4151</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Atherosclerotic Cardiovascular Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>xxx</del> (this hospital) attended the deceased from <b>January 17</b> , 19 <b>79</b> , to <b>January 25</b> , 19 <b>79</b> , that <del>xx</del> (we) last saw the deceased alive on <b>January 25</b> , 19 <b>79</b> , and that in <del>xx</del> (our) opinion death occurred on the date and hour and from the causes stated above, (UX we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Gary P. Posner</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1-26-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary P. Posner, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson</b>				ADDRESS <b>Funeral Home, Inc. Towson, MD 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. J. McElroy</b>	

22-01123

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FUNERAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01160

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE KNOWN OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST Anna			MIDDLE T.			LAST Mikulski		
3. SEX female			4. RACE white			5. DATE OF BIRTH		
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2701 Eastern Avenue			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Homemaker		
13a. STATE Md.			13b. COUNTY Baltimore			13c. STREET ADDRESS 2701 Eastern Ave		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
FIRST Felix			MIDDLE Blazucki			LAST Catherine		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218.14.4798			17. INFORMANT ADDRESS Frank Mikulski 2701 Eastern Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease								
402- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c) DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE J. Guard			TITLE (SPECIFY) Assistant			DATE SIGNED 1/9/79		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1.13.79		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem		23d. LOCATION (FOR TOWN) Baltimore	
24. FUNERAL DIRECTOR NAME Raymond L. Kaczorowski			ADDRESS 2525 Fleet		25. DATE RECD. BY REGISTRAR JAN 17 1979		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01161	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louis Edgar Milburn</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 29, 1979</b>			2b. HOUR M <b></b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 17, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b></b>		IF UNDER 24 HRS HOURS MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6907 Linden Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Balto. City Police</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3217 Hamilton Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John B. Milburn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara M. Vaeth</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-01-0131A</b>		17. INFORMANT ADDRESS <b>Mr. Brian Milburn 8626 David Ave.</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>410 - Myocardial Infarction</b> IMMEDIATE CAUSE (a) <b></b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. David Nagel</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. David Nagel MD</b>				22e. ADDRESS <b>1205 York Rd. Towson, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 31, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01162			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles C Miller</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1 9 79</i>		2b. HOUR <i>7:03 PM</i>	
3 SEX <i>M Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 30 1909</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Janitor-Balto.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Co. Educ.</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Joseph P. Miller</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha E. Goganauer</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>213-07-5669</i>		17 INFORMANT <i>3506 E. Baltimore St. Dennis Miller-Baltimore, MD 21224</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> <i>410-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Probable Myocardial Infarction</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>11/9</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/8</i> 19 <i>78</i> , to <i>1/19</i> 19 <i>78</i> , that (I) (we) last saw the deceased alive on <i>1/19</i> 19 <i>78</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>David Mishkin</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>1/19/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David Mishkin</i>				22e. ADDRESS <i>Balto. City Hosps.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/12/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem.Pk</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dorsey Howard Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Duda-Ruck, Inc</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
7922 Wise Avenue, Dundalk, MD 21222							



13-01185



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01163  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
ELIZABETH Ruby MILLER		female		white	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
May 20, 1891		87		BALTIMORE CITY MD.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland		U.S.A.		housewife	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SAINT AGNES HOSPITAL		home	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Catonsville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS	
Charles Harris		Alverta unknown		504 Hilltop Road	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT	
no		219 54 2739 J		I, Hazel France Catonsville, Md. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiorespiratory arrest					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost					
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatous					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from 1/29, 1979, to 1/28, 1979, that (X) (we) lost					
saw the deceased alive on 1/28, 1979, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Dr. Islami		MD		1/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
Dr. Islami		900 S. CATON AVE-BALTO., MD 21229		FEB 1 1979	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/31/79		Good Shepherd Cem.	
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
NAME		ADDRESS		FEB 1 1979	
SLACK Funeral Home, Ellicott City, Maryland 21043				Hazel France	

79-01163

BALTIMORE CITY

BALTIMORE SAINT AGNES HOSPITAL

300 S. CATON AVE-BALTO., MD. 21229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01164	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>GENEVIEVE Mary MILLER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>2 - 1 - 79</b>			2b. HOUR <b>12.45<sup>P</sup> M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 28 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>IF UNDER 24 HRS.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>726 Exeter Hall Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Hintenach</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Kessler</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-03-5932</b>		17. INFORMANT ADDRESS <b>Shirley Eccleston 3906 Dance Mill Rd.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Possible myocardial Infarction</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/1/79</b> <b>1/28/79</b> <b>1/28/79</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Recurrent Gastrointestinal Hemorrhage (S/P Whipple's Procedure)</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>41/79</b>		CITY OR TOWN <b>BALTO.</b>		COUNTY <b>BALTO.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/28/79</b> , 19 <b>79</b> , to <b>2/1/79</b> , 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>2/1/79</b> , 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <b>Anderson mo</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/1/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDERSON</b>				22e. ADDRESS <b>Union Memorial Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>2/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN <b>Westview</b>		COUNTY <b>Balto.</b>			
24. FUNERAL DIRECTOR NAME <b>Larsen Funeral Home</b>		ADDRESS <b>7401 Belair Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-01165	
1. DECEASED NAME (TYPE OR PRINT) <b>Hunter B. Miller</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>1 16 1979</b>			2b. HOUR <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 13, 1912</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>66 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 16 1979</b>		7d. HOUR <b>6:30P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>827 Hollins Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cloth Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>Md.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>827 Hollins Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hunter Miller</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Hollar</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes Unknown</b>				16b. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT ADDRESS <b>Glen Burnie</b> <b>Mrs. Helen McGee, 13 Marley Neck Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1/17/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn St. Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>22 Jan. 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, AA, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>James S. Kirkley, Glen Burnie, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony Kelly</i>			

23-01162



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and #2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01166 REG. NO.			
1. FOR REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Inell Miller				2a. DATE OF DEATH MONTH DAY YEAR 1/29/79			
3 SEX Female				4 RACE Negro			
5 DATE OF BIRTH MONTH DAY YEAR 3 3 1915				6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? U. S. A.			
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSP.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY			
13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME Arthur Miller				15. MOTHER'S MAIDEN NAME Caroline Bond			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 244-09-2009			
17. INFORMANT Rudolph Miller				ADDRESS 808 Allendale Street			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Metastatic Pancreatic Carcinoma</u> (c) <u>CVA &amp; Hemiparesis</u> DUE TO, OR AS A CONSEQUENCE OF: DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/19, 1979, to 1/29, 1979, that (I) (we) lost saw the deceased alive on 1/29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S.P. Peters MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. Peters MD				22e. ADDRESS 4 Shawnee Ct, #202, Balt. more, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE Rickey McCreedy	

BP

79-01160

JOHN H. B. H. H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01169			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>VELMA L. MILLER</b>				2 DATE OF DEATH MONTH DAY YEAR <b>January 28 1979</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>08 29 97</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore city</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CASHIER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FREEDON DRUG</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EMORY G. PHELPS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOROTHEA BYER</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>214-14-8374</b>		17 INFORMANT ADDRESS <b>DONALD P. MILLER, 607 GOODMAN AVENUE, 21222</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Ischy cardia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic CHF R/O Ant MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Recent Infarct Anterior MI</b> DUE TO, OR AS A CONSEQUENCE OF <b>Recent Infarct Anterior MI</b> <b>Myocardial Ischemia, Coronary Artery Disease 20 years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Ante &amp; Chronic Heart Failure, Hypertension, H/O CA vulva</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>December 28 1978</b> to <b>January 28 1979</b> , that <del>we</del> (we) last saw the deceased alive on <b>January 28 1979</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(we)</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <b>Donald P. Miller</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. DIACLETO G. GARCIA, M.D.</b>				22e. ADDRESS <b>South Baltimore General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>01-31-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Kelly</b>	

72-01162

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01167 REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>Loretta C. Miller</b>				2a DATE OF DEATH MONTH DAY YEAR <b>1-30-79</b>		2b HOUR <b>1049 AM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>06 19 95</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 JEWELRY, MEMORIAL HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1000 S. Caton Ave. Balt; Md. 21229</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Arbutus</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>4407 Leeds Avenue, 21229</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Strohmer</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Oppel</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-5504</b>		17 INFORMANT ADDRESS <b>Mary Claire Weber, 933 Circle Drive, 21227</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis</b> (c) <b>seizure disorder</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>CHE. Spontaneous rupture of aorta</b>											
19a DATE OF OPERATION <b>—</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/77</b> , 19 <b>77</b> , to <b>1/30</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James Evans M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/30/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Evans M.D.</b>		22e. ADDRESS <b>1132 N. Rolling Rd, Catonsville, Md 21228.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>02-02-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lefrey Melbrady</b>					

73-01107

Miller

James

James

James

James

James

James



RECEIVED JAN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01168

REG. NO.

238/58

1. DECEASED NAME (TYPE OR PRINT) <i>Solomon Miller</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/28/79</i>			2b. HOUR <i>6:35 AM</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 16 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>POLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Sinai Hosp.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp. of Balto.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PART-OWNER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>FOOD-A-RAMA STORE</i>	
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>BALTO.</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> XXXX		
14. FATHER'S NAME FIRST MIDDLE LAST <i>DAVID HERSH MILLER</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>RUZA ZIMMERMAN</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>214-30-3414</i>		17. INFORMANT ADDRESS <i>MRS. ROSE MILLER 5 STONEHOLLOW CT. 21208</i>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ <i>1919 Tumor (Glioblastoma) Rt hemisphere of brain - Gaggled &amp; lost apperception</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): _____									
19a. DATE OF OPERATION <i>ADP 2 weeks ago not during this admission</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Glioblastoma brain</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>1/19/79</i> to <i>1/28/79</i> , that (I) (we) last saw the deceased alive on <i>1/28/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Agrawal</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/28/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Neal Axonson</i>			22e. ADDRESS <i>Sinai Hosp of Baltimore</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>JAN. 29, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BETH TFILOH</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>		
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i>					25a. DATE REC'D. BY REGISTRAR <i>FEB 1 1979</i>		25b. REGISTRAR'S SIGNATURE <i>History/Albany</i>		

6010 REISTERSTOWN RD., BALTO. MD 21215



80110-02

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

Items #18-22a Film G527 1/16/79 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01170

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Luther Mobley		1 1 19 79		1:45 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
male	black	1/4/29	49 YRS.	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
S.C.	U.S.A.	NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	John Deaton Medical Center	Laborer	Weaver Stone		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6021 Framingham Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST			FIRST MIDDLE LAST		
Luther Mobley, Sr.			Willie Esther Hemphils		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		WWII		247 36 4203 Grace Keith 6021 Framingham Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
9888 Head injury with complications					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		3:37 PM 6/30/ 19 78		fell at home after assault	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		home		558 Robert St. Baltimore City Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Hormez R. Guard		Assistant		1/2/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Hormez R. Guard, M.D.		111 Penn Street, Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/6/79		King Memorial	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Randalstown, Md.		JAN 5 1979			
24. FUNERAL DIRECTOR		25. REGISTRAR'S SIGNATURE			
NAME ADDRESS		Rifky McCreedy			
James A. Morton & Sons 1701 Laurens					

05110-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01171			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>WOODROW MOBLEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 1 79</b> 2b. HOUR <b>5<sup>57</sup> AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 31 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1417 Winston Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bennie Mobley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Gregory</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>250-40-3053</b> 17. INFORMANT ADDRESS <b>Daisy Mobley 1417 Winston Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Large cell ca. of lung 2 metastases</b> (b) <b>1629</b> (c) <b>2 mos.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> , 19 <b>78</b> , to <b>1-1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sigrid Ulrich</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-1-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIGRID ULRICH</b>				22e. ADDRESS <b>SINAI HOSP. OF BALTIMORE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b> 25b. SIGNATURE <b>[Signature]</b>			

15110-05

MOORE

WOODROW

BLADE

WALL

15110-05

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH ANN MOERSCHER					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1979			2b. HOUR 4:45 P. M.	
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JANUARY 14, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 718 S. GRUNDY ST. # 21224				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY -----		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 718 S. GRUNDY ST. # 21224.	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK BERTCHER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-32-3612		17. INFORMANT ADDRESS CATHERINE D. MEZAN 11 CAROL AVE. ABERDEEN, 21001, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): NONE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/29/78, to 12/18/78, that (1) (we) last saw the deceased alive on 12/29/78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Victor G. Vogel MD		DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTOR G. VOGEL		22e. ADDRESS 4940 EASTERN AVE., BALTO., 21224, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-11-79		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE 7225 EASTERN BLVD. BA. CO. MD.		
24. FUNERAL DIRECTOR NAME Charles S. Gailer & Son, Inc.		ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR JAN 17 1979		25b. REGISTRAR'S SIGNATURE			

27110-27

7-1-1



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01173  
REG. NO.FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Pauline</i>		FIRST <i>Pauline</i>		MIDDLE <i>Monroe</i>		LAST <i>Monroe</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1 9-79</i>		2b. HOUR <i>5:15 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5/14/05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>				13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1613 W. Saratoga St.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert Johnson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susie Birde</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>220-63-2772</i>		17. INFORMANT ADDRESS <i>Elmiria Gross 4102 Rollins Ave.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIORESPIRATORY arrest</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of the colon</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Passive Cerebrovascular Accident</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-9</i> 19 <i>79</i> to <i>1-9</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>1-9</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Patricia Jenkins</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1-9-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Patricia Jenkins</i>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>1/13/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westport, Md.</i>			
24. FUNERAL DIRECTOR <i>Charles A. Rice</i>				ADDRESS <i>1300 Rutaw Pl.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia Jenkins</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20-01173



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01174 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Montgomery, Ruth M.</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-4-79</i>		2b. HOUR <i>6:35 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>03 08 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>55</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sauli Baltimore General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Inspector</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Glass company</i>	
13a. STATE <i>MD</i>				13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Dave Rice</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY Riffe</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>407-22-0935</i>		17. INFORMANT ADDRESS <i>Baltimore, Md. 21225</i> <i>Mr. John D. Montgomery 109 Bon Air Road</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Cervix Metastatic ca.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary edema + bronchopneumonia, bil.</i> DUE TO, OR AS A CONSEQUENCE OF (c) 1990							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-28-78</i> , 19____, to <i>1-4-79</i> , 19____, that (I) (we) lost saw the deceased alive on <i>1-4-79</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rallapalli</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1-4-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RALLAPALLI</i>				22e. ADDRESS <i>SPGH - Baltimore MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/8/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Anne Arundel Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Mc Cully Funeral Home of Brooklyn</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 9 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Hickey McBrady</i>	

45110-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01175 REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA REGINA MOONEY						2a. DATE OF DEATH MONTH DAY YEAR 1- 26-79				2b. HOUR 5:25 <sup>P</sup> M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 18, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF OVER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN DUNDALK						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7208 WOODROW AVE # 21224			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK LIGHTMAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA MILLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-07-5413		17. INFORMANT RAYMOND MOONEY		17. ADDRESS 6914 FIFTH AVE. BALTO., MD.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes with uraemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and hyperosmolar coma.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Senility, Dehydration</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/26/79</u> to <u>1/26/79</u> , that (I) (we) last saw the deceased alive on <u>1/26/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Coyunt</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NYUNT						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-30-79.		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE 7225 EASTERN BLVD., BA. CO., MD.					
24. FUNERAL DIRECTOR NAME Charles S. Giles & Son, Inc.						ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR JAN 30 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia McCreedy</u>	

BP

10-01112

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

10-7-61

ORIGINAL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01176

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
Edward Moore		1 31 19 79		6:09A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	Black	12 28 34	44 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U. S. A.	NEVER MARRIED	Baltimore City, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City	1902 Oakhill Avenue				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1902 Oakhill Avenue	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
		No			
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
Margie Combs		PART I DEATH WAS CAUSED BY:			
407 East Chase Street		IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease			
		DUE TO, OR AS A CONSEQUENCE OF			
		(b) DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Chronic renal failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Thomas D. Smith, M.D.		M.D. Deputy Chief		1/31/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTIMORE, MD.	
Thomas D. Smith, M.D.		111 Penn St.		Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	2/5/1979	King Memorial Park	Baltimore Co., Maryland		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H 1101 East North Ave.		FEB 1 1979		Anthony McCready	



13-01150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01177		
1- FOR STATE REGISTRAR			REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
HELEN M. MORETTI							JAN., 24, 79					6:35 P.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
female		white		MONTH DAY YEAR 3/ 29/ 10		68 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
New York		U.S.A.				BALTIMORE CITY MD.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		ST AGNES HOSPITAL						Housewife				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS				
Maryland		A.A.		N. Linthicum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		N. Linthicum, Md 16 Mountain Road 21090				
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST Herman Eisfeld				FIRST MIDDLE LAST Martha Alius								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)				17 INFORMANT ADDRESS				
No				?				Mr. Martin A. Bassin (as above)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of urinary bladder</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of urinary bladder &amp; metastasis (pulm)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 1/17/79, 19_____, to 1/24/79, 19_____, that (I) (we) lost saw the deceased alive on 1/24/79, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 1/24/79				
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS								
U-SIVAN				900 S. Caton Ave., Balto., Md. 21229								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial			1/27/1979		Druid Ridge		Pikesville, Balto., Md.					
24 FUNERAL DIRECTOR NAME						25a DATE RECD. BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
G. Truman Schwab 5151 Balto. Nat'l Pike						JAN 30 1979		[Signature]				

55110-85

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01178

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Grace L. Morgan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 18 79</b>			2b. HOUR M <b>9</b>					
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 20 16</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>511 N. Fulton Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>511 N. Fulton Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ash D. Merrill</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ollie Humphrey</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-14-0026</b>			17 INFORMANT ADDRESS <b>Marion Ford 511 N. Fulton Ave.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rheumatic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<b>None</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 75</b> to <b>November 19 78</b> , that (I) (we) last saw the deceased alive on <b>November 19 78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Richard M. Hunt, M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/19/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard M. Hunt, M.D.</b>			22e. ADDRESS <b>2300 Garrison Blvd. 21216</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/22/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>			ADDRESS <b>1101 E. North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Henry M. [Signature]</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

85110-25

25

JAN 2 1979

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01179  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR										2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR		2b. HOUR			
Otis						Morgan		1 13 1979		M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			
Male	Black	8 26 13		65 YRS.						1 13 1979			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				2d. HOUR			
Virginia		U. S. A.				Baltimore City,				5:33A M			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore City		3106 Reisterstown Road											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland				Baltimore				3106 Reisterstown Road					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William Morgan		Minnie Matthews											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		231-07-2532		Evelyn Morgan		3106 Reisterstown Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> 185- Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED									
Thomas D. Smith, M.D.		111 Penn St. Balto., Md.		1/13/79									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1/17/79		Mt. Auburn Cem.		Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm. C. March F/H		1101 East North Ave.		JAN 17 1979									

7a-0117a



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01180 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth Morley				January 24, 1979 2:00 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Catonsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 700 Academy Road	
14. FATHER'S NAME FIRST MIDDLE LAST late John Morley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Bridget Llanigan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 138 05 6021 A		17. INFORMANT ADDRESS Mother Mary Bernard 700 Academy Road 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) AS/HD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 725							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebro Vascular Accident							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Jan 24, 1979 to Jan 24, 1979, that (I) (we) last saw the deceased alive on Jan 24, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James Moran				DEGREE MD		22c. DATE SIGNED 1/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mallow Hill Rd				22e. ADDRESS Catonsville Md 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt de Ssles Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Maryland	
24. FUNERAL DIRECTOR Harry H. Witzke Columbia Road Ellicott City Md.				25a. DATE REC'D BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE	

08110-07



08110-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01181 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOUIS P. MORRIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 - 2 79</b>		2b. HOUR <b>1:48 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 26, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anton Morris</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Franceds K</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-07-7338</b>		17. INFORMANT ADDRESS <b>Dorothy F. Kues (sister) same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410- ARRYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>12 HRS</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SEPSIS POSSIBLE MENINGITIS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>79</b> , to <b>1-2</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1-2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Marie Posner</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIE POSNER</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schmunek Funeral Home, Inc.</b>		3331 Brehms Lane <b>Balto. Md. 21213</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

18110-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M/7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01182 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Calvin H. Morrissey, Sr.</b>						2a. DATE OF DEATH MONTH <b>1</b> DAY <b>30</b> YEAR <b>79</b>		2b. HOUR <b>M</b>			
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>31</b> YEAR <b>18</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2604 Quantico Avenue</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Md.</b>		13b COUNTY <b>Balto.</b>		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2604 Quantico Ave.</b>			
14 FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b></b> LAST <b>Morrissey</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>Matthews</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>249-16-9149</b>		17 INFORMANT ADDRESS <b>Mary G. Morrissey 2604 Quantico Ave.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>402-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-25</b> 19 <b>78</b> , to <b>7-20</b> 19 <b>78</b> , that (I) (we) lost saw the deceased alive on <b>7-20</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>M. N. Chung</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYUNG H CHUNG</b>						22e ADDRESS <b>5870 The Alameda Balto Md</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morrissey Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Turkey, N.C.</b>					
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian McCreedy</b>			

BP

78-01185

10/10/78

H.

Black

USA

1001 Franklin Avenue

Black

1001 Franklin Avenue

1001 Franklin Avenue

1001 Franklin Avenue

1001 Franklin Avenue

1001 Franklin Avenue



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified *immediately*.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <b>79-01183</b>				
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>ADOLPH</b>	MIDDLE <b>R.</b>	LAST <b>MORROW</b>	2a. DATE OF DEATH		MONTH <b>01</b>	DAY <b>15</b>	YEAR <b>79</b>	2b. HOUR <b>9:30 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS <b>74</b>		IF UNDER 24 HRS DAYS <b>YRS.</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILES</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>DIANA</b> <b>2418 DIANA RD. #21209</b>		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-05-7451</b>		17. INFORMANT <b>MRS. MONA HARTZ</b>			ADDRESS <b>DIANA</b> <b>2418 DIANA RD. #21209</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> <b>2030</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Granulocytopenia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myeloma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>Weeks</b> <b>2.5 yrs</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (this hospital) attended the deceased from <b>1/15</b> <b>1/13</b> , 19 <b>79</b> , to <b>1/15</b> , 19 <b>79</b> , that (we) lost saw the deceased alive on <b>1/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <b>Gregory L. Walker MD</b>				DEGREE				22c. DATE SIGNED <b>1/15/79</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory L. Walker MD</b>				22e. ADDRESS <b>UNION MEMORIAL HOSP. - BALTO., MD</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 17, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>AITZ CHAIM</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		COUNTY <b>MARYLAND</b>		STATE				
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. McCreedy</b>						



73-01183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <b>79-01184</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT MORTON, Jr.</b>					2a. DATE OF DEATH MONTH <b>1</b> DAY <b>18</b> YEAR <b>79</b>			2b. HOUR <b>2:45P M</b>			
3 SEX <b>Male</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>24</b> YEAR <b>19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RALEIGH, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>					13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Albert</b> MIDDLE <b></b> LAST <b>Morton, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Lela</b> MIDDLE <b></b> LAST <b>Morgan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Lenella Ruffin 2111 N. Ellamont St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>1459</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of mouth</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JANUARY 2, 1979</b> , to <b>JANUARY 18, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 18, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <b>RG Postier MD</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RG Postier MD</b>				22e. ADDRESS <b>3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/24/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <i>History of Maryland</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the deceased be examined within 24 hours after death. Page 4 may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have the funeral director file the permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01185
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN MORTON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 28 1979</b>			2b. HOUR <b>2:am M</b>		
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 2 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>					13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John E. Morton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>1908 East Madison Street</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-09-1821</b>		17. INFORMANT ADDRESS <b>Sarah Morton 1908 East Madison St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C. V. A. seizure disorder</b> (c) <b>seizure disorder</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11/79</b> 19____, to <b>1/28/79</b> 19____, that (I) (we) lost saw the deceased alive on <b>1/28/79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>S. P. Peters MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/28/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. P. Peters MD</b>			22e. ADDRESS <b>4 Shawnee Ct #202, Balt, MD 21224</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/31/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Morton</b>		

MEDICAL CERTIFICATION

78-01192

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01186

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 6 1979										2b. HOUR M 1 30
1. DECEASED NAME (TYPE OR PRINT)		FIRST SALLY		MIDDLE Eugenia		LAST MOSER						
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 1 6 1979		7d. HOUR P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Balto. General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md.		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4619 Pennington Ave.				
14. FATHER'S NAME FIRST MIDDLE LAST Steve Clay Cox						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Lee McPherson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Mr. S.J. Cox (brother)		ADDRESS Rt. # 2 Price rd. Macon Ga.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head Injury</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-31 19 78		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Apparently fell down steps						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 901 Jack St. Baltimore, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>						TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 1/7/79		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn S <sup>T</sup> reet						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/10/1979		23c. NAME OF CEMETERY OR CREMATORY Doles Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Macon Bibbs Ga.						
24. FUNERAL DIRECTOR NAME ADDRESS E. Barnes Fleming Funeral Service - Benson, Md.						25a. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE <u>Walter McCready</u>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF OF THE DIVISION OF VITAL RECORDS. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS. 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01187 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>PAUL</b> <b>MOSS</b>					2a. DATE OF DEATH		MONTH DAY YEAR <b>1 19 79</b>		2b. HOUR <b>2<sup>25</sup>A</b> M			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY OF BALTIMORE</b> MD						
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUS DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3609 10<sup>th</sup> ST</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS</b> <b>MOSS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE</b> <b>FRANK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>218 03 9750</b>		17. INFORMANT ADDRESS <b>Helen Gibowicz same as 13 e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSS. ACUTE MYOCARDIAL INFARCTION</b>		
										DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROLONGED SHOCK OF UNCERTAIN CAUSE.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCVD, AS OCECLUSIVE VASCULAR DISEASE CHH PREVIOUS MI</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>January 13, 1979</b> , to <b>January 19, 1979</b> , that (I) (we) lost saw the deceased alive on <b>January 19, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <b>M. Carrion / H.D.</b>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/19/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSE M. CARRION</b>					22e. ADDRESS <b>SBBH.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick Halbrudy</b>					

58110-05

CHITLAW

20% COTTON LIPEN



George J. Jones 4001 Atlantic Hwy  
Waco, Tex 76798  
Waco, Tex 76798  
Waco, Tex 76798

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01188	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joan R Housden						2a. DATE OF DEATH MONTH DAY YEAR Jan 10 79			2b. HOUR 6:20 A.M.		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 12 6 38		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md						13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Farrel SR						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-52-5983		17. INFORMANT JOHN FARRELL, SR. DIRECTOR XXXXXXXXXXXX 1416 RAY RD., HYATTSVILLE, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 2040 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Lymphocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Infection										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from August 1977, to Jan 1979, that (I) (we) last saw the deceased alive on Jan 10 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Janice P. Dutcher MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-10-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janice P. Dutcher MD						22e. ADDRESS BCRE, Univ. of Md Hosp					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/13/79		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION (CITY OR TOWN) BRENTWOOD		COUNTY PRINCE GEO		STATE MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE Listy, K. Bandy			
25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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PRINCE OF

28

THE SAME AS 13

11/17/79 FT. LINCOLN

FRANCIS J. COLLINS

500-UNIT-2ND W. STREET STATION, NO. 20901

JAN 12 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01189		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) <b>Delores J. Moviltz</b>					1 - 30 - 79		10 P M					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 19 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MD.</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2805 Harview Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Wills</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche M. Potter</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>212-01-6640</b>		17. INFORMANT ADDRESS <b>Walter V. Moviltz 2805 Harview Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis heart disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cardioarterial Embolism, Rt Led</b>												
19a. DATE OF OPERATION <b>1/13/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>cardioarterial Embolism</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/30/79</b> 19 <b>79</b> to <b>1/30</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1/30/79</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Arthur L. Gudwin M.D.</b> DEGREE <b>M.D.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/30/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur L. Gudwin M.D.</b>						22e. ADDRESS <b>7300 Ritchie Hwy, Glen Burnie, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 2, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>						25a. DATE REG'D. BY REGISTRAR <b>FEB 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert K. Brady</b>				

88110-05



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2011-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					79-01190	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Baby Girl Moylan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/2/79</b>		2b. HOUR <b>12:16 PM</b>	
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1/1/79</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>—</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. <b>12 22</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Pasadena</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1084 Notley Court</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Moylan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Denise Irene Baughan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Edward Moylan, 1084 Notley Court, Pasadena, Md. 21122</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized chondrodystrophy</b> <b>7564</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-JAN</b> , 19 <b>79</b> , to <b>2 JAN</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2 JAN</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death.						
22b. SIGNATURE <b>Dr. H. H. Hicken, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2 JAN 79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM E. HICKEN, M.D.</b>				22e. ADDRESS <b>ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE MD. 21229</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>01-03-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Gar. of Mem. MARRIOTTSTVILLE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HOWARD MD</b>
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE PREPARED BY REGISTRAR <b>JAN 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

BP



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M

BALTIMORE CITY

ST. JOHNS HOSPITAL

BALTIMORE

REPORT OF PHYSICIAN

DATE

PT

WAS

PT

WAS

PT

WAS

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ST. JOHNS HOSPITAL

REPORT OF PHYSICIAN

*Handwritten signature*

01-2-75

1975

HOSPITAL ST. JOHNS, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01191

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
EUNICE		M.		MULLINEAUX	1		2	79	935	A.M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS		
Female	White		Jan. 30, 1909		69		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE CITY		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		UNION MEMORIAL HOSPITAL				Housewife					
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					13e. STREET ADDRESS	
Mark					Mary					5660 Woodmont Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
No					214-24-3995		Leroy C. Louis, Jr. 1302 Vermont Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIAC ASYSTOLE 2° Bradycardia										10 minutes	
4148 DUE TO, OR AS A CONSEQUENCE OF (b) POOR MYOCARDIAL FUNCTION, CHF										2 months	
DUE TO, OR AS A CONSEQUENCE OF (c) ANTERIOR MYOCARDIAL INFARCTION										2 1/2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 12/26, 1978, to 1/2, 1979, that (we) lost saw the deceased alive on 1/2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John F. Bober MD								DEGREE		22c. DATE SIGNED	
								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
JOHN F. BOBER, M.D.								UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN			
Burial				Jan. 6, 1979		Parkwood		Baltimore			
								COUNTY		STATE	
								Md.			
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Baltimore, Md.								JAN 3 1979		Leroy C. Louis, Jr.	

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MURKIN

10110-01

Jan 20, 1999

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01192			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>Sister M. Brendan Murphy</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>29</b> YEAR <b>79</b> 2b. HOUR <b>9:20A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>17</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Religious Sister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>of Mercy</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Patrick</b> MIDDLE <b>Murphy</b> LAST <b>Murphy</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Murphy</b> LAST <b>Murphy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>218-54-2015</b>		17. INFORMANT ADDRESS <b>Sr. Mary Thomas, 301 St. Paul St. Balto., Md.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Histiocytic Lymphoma</b> 2000 DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> , 19 <b>78</b> , to <b>1/29</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Fredric Stewart Sirkis MD</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/29/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDRIC STEWART SIRKIS</b>	
22e. ADDRESS <b>MERCY HOSP. 301ST. PAUL ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc., 6500 York Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCurdy</b>	

50-01105

100-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01193

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 15 19 79		2b. HOUR M 9:13 P.M.
1. DECEASED NAME (TYPE OR PRINT)		21. DATE PRONOUNCED DEAD 1 15 19 79		2d. HOUR P.M.
2. SEX male		3. RACE White		4. DATE OF BIRTH MONTH DAY YEAR 5/11/18
5. AGE (IN YEARS) (LAST BIRTHDAY) 60 YRS.		6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
11. CITY OR TOWN OF DEATH Baltimore		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1202 Union Avenue		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		15. CITY OR TOWN BALTO.		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
17. STREET ADDRESS 1206 UNION AVE		18. FATHER'S NAME FIRST MIDDLE LAST ? ? ?		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		21. SOCIAL SECURITY NO. 212-16-2163		22. INFORMANT ADDRESS BRADY MUSGROVE 236 CHANTLEY DR.
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4392 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED?		26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE
33. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Virginia L. Dolan		TITLE (SPECIFY) Assistant		DATE SIGNED 1/16/79
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201		
34. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		35. DATE 1/19/79		36. NAME OF CEMETERY OR CREMATORY MAYSCHAPEK
37. LOCATION CITY OR TOWN BALTO., CO.		38. COUNTY BALTO., CO.		39. STATE MD.
40. FUNERAL DIRECTOR NAME Paul E. Leonard		41. ADDRESS 17 Chestnut St.		42. DATE REC'D. BY REGISTRAR JAN 19 1979
43. REGISTRAR'S SIGNATURE M. J. McCready		44. DATE JAN 19 1979		45. REGISTRAR'S SIGNATURE M. J. McCready

28-01133

RECEIVED  
FBI - NEW YORK  
JAN 10 1964

MEMORANDUM

TO :

FROM :

SUBJECT :

DATE :

TIME :

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01194 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) INEZ MYERS				2a. DATE OF DEATH MONTH DAY YEAR 1 23 79			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 6 9 1934		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Effie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mouzon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 247-50-3138		17. INFORMANT ADDRESS Willie Myers 1719 East 31st Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral bleeding - to rupture of</u> 430- <u>being aneurysm.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 #
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 1.22.79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED critical		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>January 22</u> 19 <u>79</u> , to <u>Jan 23</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Jan 23</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1.23.79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. PTHAM		22e. ADDRESS Union Memorial Hosp. Balt. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/79		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Stephens, S. C.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 25 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

78-01184

Handwritten signature

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01195 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCIS ANTHONY NAPFEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 19, 1979</b>		2b. HOUR <b>10:30 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 27, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3822 FAIT AVE. # 21224</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	
13a. STATE <b>MD.</b>		13b. COUNTY -----	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD J. NAPFEL (NAPFEL)</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA GUCKERT</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II 216-07-8181</b>		17. INFORMANT ADDRESS <b>CHARLES J. NAPFUL : 3822 FAIT AVE. BALTO., 21224, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ <b>431-</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hypertension secondary to arteriosclerotic heart disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>did not</del> attended the deceased from <b>1-23</b> 19 <b>78</b> , to <b>12-23</b> 19 <b>78</b> , that (I) <del>do</del> last saw the deceased alive on <b>12-23</b> 19 <b>78</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>did not</del> view the body after death.					
22b. SIGNATURE <i>Melito M. Torres</i> DEGREE				22c. DATE SIGNED <b>1-22-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MELITO M. TORRES</b>				22e. ADDRESS <b>441 S. ELLWOOD AVE., BALTO., 21224, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM</b>	
23d. LOCATION CITY OR TOWN <b>7401 GERMAN HILL RD., BA. CO., MD.</b>		23e. COUNTY <b>BA. CO.</b>		23f. STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Siler, Son, Inc.</i>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1979</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

20110-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01196 REG. NO.			
1. FOR - STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) <b>ANTON</b> <b>ANTON</b> <b>NEAGUL</b>					2a. DATE OF DEATH MONTH <b>JANUARY</b> DAY <b>30</b> YEAR <b>1979</b>		2b. HOUR <b>7:00 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>10</b> YEAR <b>11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7. IF UNDER 24 HRS HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>105 N. Port St.</b>	
14. FATHER'S NAME FIRST <b>Dionysius</b> MIDDLE <b></b> LAST <b>Neagul</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Julia</b> MIDDLE <b></b> LAST <b>Grassi</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>218-36-0615</b>		17. INFORMANT ADDRESS <b>Theresa Neagul 105 N. Port St.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST, SECONDARY MYOCARDIAL INFARCTION</b> <b>5920</b> DUE TO, OR AS A CONSEQUENCE OF <b>UREMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Sec/ URAEMIA</b> DUE TO, OR AS A CONSEQUENCE OF <b>SECONDARY OBSTRUCTED LEFT KIDNEY DUE TO STONE</b> (c) <b>(SOLITARY)</b> PART 2. OTHER SIGNIFICANT CONDITIONS (CONDITIONS LEADING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1) <b>OBSTRUCTED SOLITARY KIDNEY</b>													
19a. DATE OF OPERATION <b>1-30-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STONE OBSTRUCTED LEFT KIDNEY</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <b>1-28</b> 19 <b>79</b> , to <b>1-30</b> 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>1-30</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Sompalli</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>1-30-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. K. PRASAD SOMPALLI, M.D.</b>					22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION</b> <b>100 N. BROADWAY, BALTIMORE, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Md.</b>							
24. FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; Son</b> ADDRESS <b>2818 E. Baltimore St.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>						

10-01186



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (S))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01197

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) ROBERT ADAMSON NEHRKORN		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR		2b. HOUR	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE IN YEARS LAST BIRTHDAY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SMELTER		12b. KIND OF BUSINESS OR INDUSTRY PEMCO CORP.	
13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN EDGEMERE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE NEHRKORN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1953-1961	
17. INFORMANT LINDA A. NEHRKORN		18. ADDRESS Box No. 181 A/Ave. B RT. 10 # 21219, MD.		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1/6/79	
ACTUAL SIGNATURE Virginia L. Dolan M.D.		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1/6/79	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 9, 1979	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 9, 1979		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE KENWOOD AVE., OVERLEA, MD.	
24. FUNERAL DIRECTOR NAME Charles S. Seiler & Son, Inc.		ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR JAN 10 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION



72110-25

11101010101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01198	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) LONNIE E. NEICE			2a. DATE OF DEATH MONTH DAY YEAR 1 - 12-79			2b. HOUR 10:36 PM					
3 SEX MALE		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 21 38		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N/A		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1308 Hollins St.		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Neice			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Mary Nollie Lucas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Known			16b. SOCIAL SECURITY NO. 22548-1900		17. INFORMANT Betty Neice		ADDRESS 1308 Hollins St.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypovolemia - Shock 303- Conditions: if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) Massive upper GI. bleed DOE TO, OR AS A CONSEQUENCE OF (c) 20 EtOH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Disseminated intravascular Coagulation (DIC)											
19a. DATE OF OPERATION 1/12/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Massive GI. bleed				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/12 19 79 to 1/12 19 79, that (I) (we) lost saw the deceased alive on 1/12 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ray Brodie, M.D.				DEGREE		22c. DATE SIGNED 1/12/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ray Brodie, Jr. M.D.				22e. ADDRESS Univ Md Hosp Balt Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/79		23c. NAME OF CEMETERY OR CREMATORY Westview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balt Co. Md					
24. FUNERAL DIRECTOR John J. Bowman & Son				25a. DATE REC'D. BY REGISTRAR 90 Hollins		25b. REGISTRAR'S SIGNATURE [Signature]					

JAN 18 1979

80110-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01199 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CARRIE NELSON</b>					2a. DATE OF DEATH MONTH <b>1</b> DAY <b>29</b> YEAR <b>79</b>			2b. HOUR <b>1:30</b> <sup>A</sup> <sub>M</sub>			
3. SEX <b>FEMALE</b>		4. RACE <b>NEGROID</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>8</b> YEAR <b>1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> <sup>MD.</sup>					
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CITY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>467 WALTON CT.</b>			
14. FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b></b> LAST <b>DORSEY</b>				15. MOTHER'S MAIDEN NAME FIRST <b>LUCY</b> MIDDLE <b></b> LAST <b>WATERS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>220-46-4855 J1</b>		17. INFORMANT <b>Evelyn Wms.</b>		ADDRESS <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>7991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Dementia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/1/75</b> , 19 <b>75</b> , to <b>1/29</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Paul Fishman</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Fishman</b>						22e. ADDRESS <b>BCH</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARbutus MEM.</b>			23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>VERNON BAILEY</b> ADDRESS <b>1348 CALHOUN ST.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Pistayalandy</b>			

MEDICAL CERTIFICATION

3

1708

53-01188

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01200 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Cleveland Nelson										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 23 19 79										2b. HOUR M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 6 11		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 1 25 19 79										2d. HOUR 10:03 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.											
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 725 George Street, Apt. 11-R								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 725 George Street							
14. FATHER'S NAME FIRST MIDDLE LAST Willie Nelson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Brown																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS Christine Kennedy 1100 Penn. Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Virginia L. Dolan, M.D.						TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 1/25/79											
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 1/29/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Maryland									
24. FUNERAL DIRECTOR NAME Wm. C. March F/H												ADDRESS 1101 East North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 26 1979		25b. REGISTRAR'S SIGNATURE Patty Kellogg					

00510-07



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01201 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) 2 ZELINDA NENCINI			2a. DATE OF DEATH January 12, 1979		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH March 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. STATE Md.			13b. COUNTY ---	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Eugenio Nencini			15. MOTHER'S MAIDEN NAME Angela Villani		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-14-5383		17. INFORMANT ADDRESS Dr Louis Breschi 1428 A West Joppa Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm.</u> 4415 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Congestive heart failure.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Hypertensive Vascular Disease.</u>					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>75</u> , to <u>January</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>January 3rd</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>H. Darwish</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/13/1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mandouh Darwish		22e. ADDRESS 1910 Lyden Rd., Lutherville, Md.			
23a. BURIAL OR CREMATION (SPECIFY) Burial		23b. DATE 1/15/79		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.			
25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE <u>Fitzroy Melby</u>			

10510-05

b 0200-2102

M C 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0909  
BP  
DHMH-16 50M 7/77  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01202

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	MIN
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		
DORA LEE NEWLIN		1		1		79		8:12 P
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE	Negro	MONTH DAY YEAR 12-2-1917		61 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Burlington N.C.	USA			Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	JOHNS HOPKINS HOSPITAL		Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS				
Ollie		UNKNOWN		1743 E. North Ave. Balt. MD.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		214-03-3567A		Robert V. Lee				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								1 day
IMMEDIATE CAUSE (a) Hypotension								
DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Intravascular Coagulation								2-3 days
DUE TO, OR AS A CONSEQUENCE OF (c) Unknown etiology - Probable Sepsis n Ca.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
None KNOWN								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from 12/27 1978, to 1/1 1979, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 1/1 1979, and that in my opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Oscar L. Laskin		M.D.				1/1/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
LASKIN		Johns Hopkins.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1-8-79		Mt. Calvary Cemetery				
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
William J. Spicer		JAN 4 1979		[Signature]				

58-01505



NAME: [illegible]  
ADDRESS: [illegible]  
CITY: [illegible]  
STATE: [illegible]  
ZIP: [illegible]

HYPO-TENSION  
[illegible]  
[illegible]

LAST IN  
[illegible]  
[illegible]  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. <b>79-01203</b>	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR	
		ETHEL E. NEWMAN		1/5/79	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	
Female		White		2-14-1895	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN	
West Virginia		U.S.A.		83	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Belair Convalesarium		Baltimore City MD.	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b STREET ADDRESS	
13a STATE CITY OR TOWN				4410 Glenmore Avenue-21206	
Md. Balto.		Balto.			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17 INFORMANT ADDRESS	
Thomas Jarratt		Addie May Baker		21206	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
No		235-12-3577		Mrs. Alma L. Mehlich 4410 Glenmore Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- CARDIAC ARRHYTHMIA 27 TO 14 MYOCARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIAC DIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 5/3 1977 to 1/5 1979, that (I) (we) last saw the deceased alive on 1/5 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		22b SIGNATURE DEGREE		22c DATE SIGNED	
Luis E. Rivera M.D.		50 Scott Adam Road Cockeysville, Maryland 21030			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-9-79		23c NAME OF CEMETERY OR CREMATORY Odd Fellows Cem.	
23d LOCATION CITY OR TOWN COUNTY STATE		23e NAME OF CEMETERY OR CREMATORY		23f LOCATION CITY OR TOWN COUNTY STATE	
Shinnston, West Va.					
24 FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
		JAN 10 1979			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01204 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES ADDISON NICHOLS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 7, 1979</b>				2b. HOUR <b>4:45 A.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 1, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SALEM, VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1229 JOPLIN ST. #21224</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DISABILITY</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1229 JOPLIN ST. # 21224.</b>				
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK NICHOLS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LONEY ICEY SAILOR</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>224-20-0530</b>		17. INFORMANT ADDRESS <b>JAMES NICHOLS ; 1229 JOPLIN ST. BALTO., 21224, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2500 Congestive H. Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Cardiac enlargement</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6002 EASTERN AVE., BALTO., 21224, MD.</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>December 19 78</b> , to <b>December 19 78</b> , that (I) (we) last saw the deceased alive on <b>December 19 78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Albert Chalom</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT CHALOM</b>				22e. ADDRESS <b>6002 EASTERN AVE., BALTO., 21224, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>Charles J. Sullivan &amp; Son, Inc.</b>				6224 EASTERN AVE. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>			

BP



12-01504

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5-FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM-17  
(VR A15 ME (J))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01205

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Lotty Vera Nicholson		1 3 19 79		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	White	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS DAYS	HOURS MIN.
		June 2, 1901	77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED
Maryland	U.S.A.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore City	University Hospital (STU)	Housewife			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Baltimore	Catonsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21228	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	17. INFORMANT			
George H. Schaefer	Martha Shaull	ADDRESS 1407 Vermont Rd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	Mr. Ernest N. Bortner Bel Air, Md.			
(YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple Injuries					
8147					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR MONTH DAY YEAR		Pedestrian struck by auto	
		1:50 P.M. 1 3 19 79			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		street		Frederick Rd.	
				Baltimore, Md.	
22a. I certify that I took charge of the remains described above, held on					
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		1/4/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	1/6/1979	Loudon Park		Baltimore, Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		21229		JAN 8 1979	
G. Truman Schwab 3512 Frederick Ave.					

20510-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01206	
1. FOR STATE REGISTRAR			24. DATE OF DEATH MONTH DAY YEAR 26. HOUR		
1. DECEASED NAME FIRST MIDDLE LAST HARRIETT R. NOEL			JAN.-12- 79 9:40 P		
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1914	6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 103 Beaumont Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST George R. Noel			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Naomil R Ely		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-12-7743	17. INFORMANT ADDRESS Mr. Aaron Margolis Baltimore, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 16 29 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Secondary to liver</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sivan</i>		DEGREE M-D ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) V. SIVAN		22c. ADDRESS V. SIVAN			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/16/79	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Md.
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136			25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE <i>notary, ready</i>

BP

79-01506



BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

100 South Ave.

Baltimore

Md.

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10

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10

10

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10

Baltimore

West Haven Cemetery

10

10

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01207 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARNOLD K. NORDEN				1-26-79				12 <sup>40</sup> P.M.			
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-30-14		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR HARVEY STAMBAUGH & Son			
13a. STATE Maryland				13b. COUNTY —		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1436 Andre ST.	
14. FATHER'S NAME FIRST MIDDLE LAST Adolph NORDEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna LUCKHART							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-03-6966		17. INFORMANT ADDRESS Lydia W. Norden 1436 Andre ST.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARRHYTHMIA</u> 4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>INFERIOR MI</u> (c) <u>RUPTURED ABD AORTIC ANEURYSM</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>ASCVD, HBP</u>											
19a. DATE OF OPERATION 1-26-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED AORTIC ANEURYSM				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I (this hospital) attended the deceased from <u>1-26</u> , 19 <u>79</u> , to <u>1-26</u> , 19 <u>79</u> , that (I (we) last saw the deceased alive on <u>1-26</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) did not view the body after death.											
22b. SIGNATURE <u>Patricia A. Snello</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-26-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. SNELLO				22e. ADDRESS MERCY HOSP.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-29-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Charles L. Stevens Funeral Home, Inc. 1561 E. Fort Ave.						25a. DATE REC'D. BY REGISTRAR JAN 29 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia A. Snello</u>			

20510-02



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01208 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA ELIZABETH NORMAN					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5, 1979			2b. HOUR 9:30 P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR August 13, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8316 Nunley Dr, Apt. F			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookbinder		12b. KIND OF BUSINESS OR INDUSTRY Waverly Press				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Baltimore Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William V. Michael					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Marburger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 214-05-3560		17. INFORMANT ADDRESS Mr. Edward M. Norman 8316 Nunley Drive					
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease several years (c) A S C V D + Hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE 73 the present.					
22a. I certify that (I) (the hospital) attended the deceased from 2-13 19 73 to the present, 19 78, that (I) (we) lost saw the deceased alive on Nov 15 19 78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Carlos E. Aranaga						DEGREE M.D.		22c. DATE SIGNED 1-6-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Carlos E. Aranaga						22e. ADDRESS 1900 E. Northern Pky.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-9-1979		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 8 1979			
						25b. REGISTRAR'S SIGNATURE History McCreedy					

MEDICAL CERTIFICATION

80810-05

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01209  
REG. NO.1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>ELSIE</b>		FIRST <b>M</b>		MIDDLE <b>NOVAK</b>		LAST		2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>20</b> YEAR <b>1979</b>				2b. HOUR <b>4<sup>10</sup> A.M.</b>		
3 SEX <b>FEMALE</b>		4 RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>18</b> YEAR <b>13</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.				IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.								
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE GOOD SAMARITAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Box Dept.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Levies Hat Co</b>				
13a STATE <b>MARYLAND</b>				13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 685, Rt 15, BALTO, MD, 21220</b>				
14 FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b></b> LAST <b></b>				15 MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b></b> LAST <b></b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-22-0173</b>		17 INFORMANT ADDRESS <b>John Novak (husb) same as 13</b>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GANGRENE BOTH LEGS.</b>														
19a. DATE OF OPERATION <b>N/A</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b></b> YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-14-</b> 19 <b>79</b> to <b>1-20-</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1-20-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.														
22b. SIGNATURE <b>Vundyal V. Reddy</b>				DEGREE <b></b>				22c. DATE SIGNED <b>1-20-79</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUNDYALA V. REDDY</b>				22e. ADDRESS <b>THE GOOD SAMARITAN HOSPITAL 5601 Lockraven Blvd, Balto, MD; 21239.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National</b>				23d. LOCATION CITY OR TOWN <b>Baltimore,</b> COUNTY <b></b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR <b>Schamunek Funeral</b>				3331 Brehms Lane <b>Balto. Md. 21213</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Vundyal V. Reddy</b>				

35  
44  
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23  
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2  
1

Page 4 may be attached to this certificate if the deceased was under 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified promptly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified promptly.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

13-01508



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM-3" RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01210

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. HOUR
Ruth		L.		Nowinski	DATE KNOWN OF DEATH	ESTIMATED	MONTH DAY YEAR
3. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS.	2d. HOUR
Female		White	12/24/15	63 YRS.	MONTHS	DAYS	11:41A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		U.S.A.				Baltimore City, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore City		Baltimore City Hospital		Scouter		SocSec	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland		-	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5068 Orville Ave. 21205		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Ewell Hess		UNKNOWN		16b. SOCIAL SECURITY NO.			
				17. INFORMANT			
No		-		3941 Lyndale Ave. 21213			
				Milton Nowinski (step-son)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Thomas D. Smith		Deputy Chief		1/17/79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTIMORE, MD.			
Thomas D. Smith, M.D.		111 Penn St.		Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		1/19/79	Holy Rosary Cem.		Baltimore, Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schamunek Funeral Home, Inc.		JAN 18 1979		Rickey McCreedy			

01510-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01211  
R.G.O.

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 17 79										2b. HOUR M 19																	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John A. Oakley										3. SEX male										4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 1 29 41				6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 17 79				2d. HOUR P.M. 2:23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S. A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.																						
10. CITY OR TOWN OF DEATH Baltimore					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY																	
13a. STATE Maryland										13b. COUNTY					13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS 1715 North Montford Avenue												
14. FATHER'S NAME FIRST MIDDLE LAST Jonas Oakley										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline German																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 219-38-1696					17. INFORMANT ADDRESS Eugene Anderson 2421 E. Madison St.																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale and Pulmonary Fibrosis</u> 515- Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																					
ACTUAL SIGNATURE <u>Thomas D. Smith</u>					TITLE (SPECIFY) M.D. Deputy Chief										DATE SIGNED 1/18/79																						
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.					ADDRESS 111 Penn Street, Balto., MD 21201																																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 1/22/79					23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.					23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland																						
24. FUNERAL DIRECTOR NAME Wm. C. March F/H										ADDRESS 1101 East North Ave.					25a. DATE REC'D. BY REGISTRAR JAN 19 1979					25b. REGISTRAR'S SIGNATURE <u>Anthony M. Cassidy</u>																	



11510-01

#17 g528 2/5/79 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01212

1. DECEASED NAME (TYPE OR PRINT) <b>DELLA CAROLINE OBRIEN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 29 79</b>		2b. HOUR <b>7<sup>15</sup> AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 28 16</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Luthern Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>			
13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Woodlawn</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert L. Zerrlaut</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della B. Kane</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		17. INFORMANT <b>O'Brien</b> ADDRESS <b>Louis O'Brien 2012 Russell Ave. 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b> <b>2398</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension - renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPTICEMIA - sepsis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15'</b> <b>8 days</b> <b>19 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>MALIGNANT MESOTHELIOMA - PNEUMONIA - MASSIVE ASCITES</b>					
19a. DATE OF OPERATION <b>1-3-79 / 1-15-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABDOMINAL TUMOR / STRESS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>ULCER</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/26, 1978</b> , to <b>1/25, 1979</b> , that (I) (we) last saw the deceased alive on <b>1/29/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Pelayo E. Correa</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PELAYO E. CORREA</b>		22e. ADDRESS <b>LUTHERAN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-1-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Stansbury Funeral Home 6411 Windsor Mill Rd.</b>		25a. DATE RECEIVED BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Crady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

58-01515

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01213

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THEODORE JOHN DECHSLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 1, 1979</b>		2b. HOUR <b>M</b>
3 SEX <b>M</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 9, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>426 N. ROSE ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICIAN</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>CITY</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MD</b>	13b. COUNTY <b>—</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>426 N. ROSE ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN T. DECHSLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET DETZER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-01-1554</b>		17. INFORMANT ADDRESS <b>Mrs. Clara C. Dechslor 426 N. Rose St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1973</b> to <b>DEC</b> 19 <b>78</b> , that (I) (we) last saw the deceased alive on <b>DEC 21</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles L. MacMinn MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>JAN 3, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN 4, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR NAME <b>Barth Miller</b>		ADDRESS <b>2334 Jefferson St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Barth Miller</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13-01513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01214	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Gerard A. OGLE</b>			2a. DATE OF DEATH <b>January 26 1979</b>				2b. HOUR <b>10 30 AM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>June 17 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7 IF UNDER 1 YEAR MONTHS OAYS		8 IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3310 Ellerslie Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>		
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3310 Ellerslie Ave.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Ogle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Strohecker</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-03-9306</b>		17. INFORMANT <b>Marie T. Ogle</b>			ADDRESS <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive C.V.D.</b> 402 - DUE TO, OR AS A CONSEQUENCE OF (b) <b>Secondary Polycythemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>4 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>may</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>may</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the <b>same</b> date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Isadore K. Grossman M.D.</b>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>1/27/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Isadore K. Grossman M.D.</b>						22e. ADDRESS <b>3409 Rosedale Rd., Balto., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Balto. Md.</b>			
24 FUNERAL DIRECTOR NAME <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

13-01514



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01215

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD A. OLES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 05 79</b>			2b. HOUR <b>0055 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 02 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4303 Berger Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>sheet-metal fab.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4303 Berger Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Oles</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT ADDRESS <b>Mrs. Helen A. Oles 4303 Berger Avenue</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure, sepsis with cardiopulmonary arrest</b> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral ureteral obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Widely metastatic carcinoma of colon</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mths</b> <b>5 yr.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic cardiovascular disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>October 6</b> , 19 <b>78</b> , to <b>January 5</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>December 5</b> , 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.									
22b. SIGNATURE <b>Charles S. Angell, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles S. Angell, M.D.</b>						22e. ADDRESS <b>611 Park Avenue Balto., Md. 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-8-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McCreedy</b>	

73-01512

01 02 73 0030

0112

DEBING

21

03

02

White

Male

Division of

U.S.A.

Sheet-metal fab.

303 Barber Avenue

Baltimore

1303 Barber Avenue

Baltimore

Maryland

219-07-1620

renal failure, azotemia with cardiovascular arrest

dilatation, ureteral obstruction

highly metastatic carcinoma of colon

atherosclerotic cardiovascular disease

January 2 73

October 2 73

December 2 73

611 Park Avenue, Baltimore, Md. 21201

Charles S. Wolf, M.D.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01216

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES Weschler ONDRICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 12 1979</b>			2b. HOUR <b>3:55A</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 25, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Biology Depart.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Geo. Univ.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>D.C.</b>		13b. COUNTY <b>None</b>		13c. CITY OR TOWN <b>Washington, DC</b>		13e. STREET ADDRESS <b>3625 Ordway Street. N.W.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam Weschler</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie McCormick</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>577-36-8204</b>		17. INFORMANT ADDRESS <b>Son, John L. Ondrick 814 Leigh Mill Rd. Great Falls, Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>enterocutaneous fistula; retroileal leak</b>										
19a. DATE OF OPERATION <b>Aug 3, 1978</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>cancer of colon; urinary tract</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1978</b> to <b>January 12, 1979</b> , that (I) (we) last saw the deceased alive on <b>Jan. 11, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Michael J. Drouin</b> MD					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan 12, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael J. Drouin</b>					22e. ADDRESS <b>DEPT UROLOGY / JOHNS HOPKINS HOSP</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 15, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician, it should be completed, filled in, and signed by the funeral director, page 3 should be detached for use on the burial-transit permit. When please remove tabular paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, death is presumed to be homicidal or suicidal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01217	
1. FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) ALONZA O NEAL			2a. DATE OF DEATH MONTH DAY YEAR 1 24 79		2b. HOUR 6 P. M.
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 26 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3403 WOODBROOK AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. STREET ADDRESS 3403 WOODBROOK AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST Lee O'Neal		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Althea Albert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 210-10-1438A		17. INFORMANT ADDRESS Medical Examiner	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>78</u> , to <u>5-18</u> , 19 <u>78</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry Wasserman M.D.				22c. DATE SIGNED 1-25-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Wasserman M.D.				22e. ADDRESS 1561 Eutaw Place 21217	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/29/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24. FUNERAL DIRECTOR NAME ARLINGTON S. PHILLIPS		24b. ADDRESS 1721-27 N. MONROE ST.		25a. DATE REC'D. BY REGISTRAR JAN 29 1979	
25b. REGISTRAR'S SIGNATURE R. J. McCreedy					

70-01517

RECORDS

1965

1965



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01218

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>TEOLA</b>		FIRST <b>Oneal</b>		MIDDLE		LAST		2a DATE OF DEATH MONTH <b>1</b> DAY <b>27</b> YEAR <b>79</b>		2b HOUR <b>6:20A</b> M	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH <b>3</b> DAY <b>30</b> YEAR <b>1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>city</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Maryland</b>				13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>3403 Woodbrook am.</b>	
14 FATHER'S NAME FIRST <b>Joe</b> MIDDLE <b>Mc Bee</b> LAST <b>Mc Bee</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Mc Bee</b> LAST <b>Mc Bee</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO.		17 INFORMANT <b>Aretha Epps</b>		ADDRESS <b>13 Coledgy Ave. Greenville S.C. 29607</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> f											
42374 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Cardio myopathy</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Winston H Williams MD</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>1/27/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Winston H Williams</b>				22e ADDRESS <b>40 Woodland Hospital, 90 Dept of Medicine</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>2-1-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Int. Auburn</b>		23d LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Arlington S. Phillips</b>				ADDRESS <b>1721-27 N. Monroe St.</b>		25a DATE REC'D. BY REGISTRAR <b>JAN 31 1979</b>		25b REGISTRAR'S SIGNATURE <b>Winston H Williams</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01219 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OLEN G ORNDUFF</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 9 79</b>				2b. HOUR <b>12:10 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 11 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 74 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTIMORE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>self-Emp</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>O-GO Sales</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4942 ABERDEEN AVENUE 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Ornduff</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Minnick</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Mrs. Olen Ornduff 4942 Aberdeen Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic pulm. fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>recurrent pleural effusion - prob. cancer</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>congestive heart failure, metastatic squamous cell Ca</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) this hospital attended the deceased from <b>DECEMBER 28, 19 78</b> , to <b>JANUARY 9, 19 79</b> , that (X) (we) last saw the deceased alive on <b>1/9/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <b>W. A. Riley</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/9/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. A. Riley</b>				22e. ADDRESS <b>3900 LOCH RAVEN BLVD. BALTO. MD. 21218</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>				ADDRESS <b>1005 Dundalk Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01220 REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH Elizabeth OTEY										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 18 19 79	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Set. 30, 07		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 71		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR 9:51 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 412 S. Exeter St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Virginia				13b. COUNTY Colonial Bch.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 2014 Beach Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Christian S. Lantz						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Caldwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-07-3446		17. INFORMANT ADDRESS 6210 Hope Drive C.C. Lowe, Sr. Temple Hills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 1-19-79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/22/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G., Maryland			
24. FUNERAL DIRECTOR NAME C.F. Beall Lee Funeral Home, Clinton, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

72-01550

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25 74.07.94

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		79-01221 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		1st. DATE OF BIRTH		2b. DATE OF DEATH	
Raymond		H		Overfelt	
3. SEX male		4. RACE White		5. DATE OF BIRTH Nov. 7, 1942	
6. AGE 36 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
11. CITY OR TOWN OF DEATH Baltimore		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Curtis Avenue/auto garage		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	
14. STATE Maryland		15. COUNTY Baltimore		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. FATHER'S NAME Raymond		18. MOTHER'S MAIDEN NAME Henrietta		19. STREET ADDRESS 1528 Light St. Balto. Md.	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		21. SOCIAL SECURITY NO. 220-38-7617		22. INFORMANT Mrs. Henrietta Overfelt, 1532 Light St.	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of head</u> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
24a. DATE OF OPERATION		24b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		25. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
26a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		26b. TIME OF INJURY 1:45 P.M. 1/18/79		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot by assailant	
27a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) auto garage		27c. LOCATION 4701 Curtis Avenue, Balto., MD	
28a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER DATE SIGNED 1/18/79	
ACTUAL SIGNATURE Virginia L. Dolan, M.D.		M.D. Assistant		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street, Balto., MD 21201			
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		29b. DATE 1-22-79		29c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
30a. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Balto. Md.		30b. DATE REC'D. BY REGISTRAR JAN 23 1979		30c. REGISTRAR'S SIGNATURE Fitzroy McHardy	

15510-02



Item #19b Film G529 3/6/79 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01222

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		1 24 79		1155 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		Cauc.		5 07 03		75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Dodd Sanatorium Hospital		School Teacher Balto. Cit			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Md.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6013 Eunice Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
William D. McLain		Mary Ann Gordon				216-20 9688	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE POLM. EMBOLISM OR 7159		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS	
family				DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION			
				DUE TO, OR AS A CONSEQUENCE OF 2 WKS S/P (R) TOTAL HIP REPLACEMENT			
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
1/3/79		DID (R) HIP		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 79 to 1/24 19 79, that (I) (we) last saw the deceased alive on 1/24 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Thomas A. Collier MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Thomas A. Collier MD		Good Sam Hosp., Balt., Md.		burial		1/27/79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Holy Redeemer		Balto. City, Md.		NAME ADDRESS		25b. REGISTRAR'S SIGNATURE	
				Evans Funeral Chapel 2325 York Road		JAN 29 1979	

99-01555

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School Teacher, Delco, Ct.

1015 Elmira Avenue

2A

Delco, Ct.

Del.

Harry W. Gordon

William J. McLean

Twenty

2 Elmira Ave., Delco, Ct.

Harry W. Gordon

1015 Elmira Ave.

Delco, Ct.

Evans - General, 1015 Elmira Ave., Delco, Ct.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01223 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT PAGE</b>				2a. DATE OF DEATH MONTH DAY YEAR 1-8-79 2b. HOUR 11:25 A.M.			
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR March 3, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN LEATON MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Page			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17 INFORMANT ADDRESS Mark Oliver F/H Crew, Virginia			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7070				(b) Infected decubiti 2 wks			
				(c) Chronic Brain Syndrome years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 1/8/79 to 1/8/79, that (we) lost saw the deceased alive on 1/8/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
22b. SIGNATURE J. P. Ryan				DEGREE		22c. DATE SIGNED 1/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>			
				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/1979		23c. NAME OF CEMETERY OR CREMATORY Fowlkes Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crew, Virginia	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE	

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RECEIVED

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RECEIVED

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10-01553

NAME: William Page

DATE OF DEATH: March 3, 1979

PLACE OF DEATH: Baltimore City

SEE: # 79-03942  
February, 1979  
Baltimore City



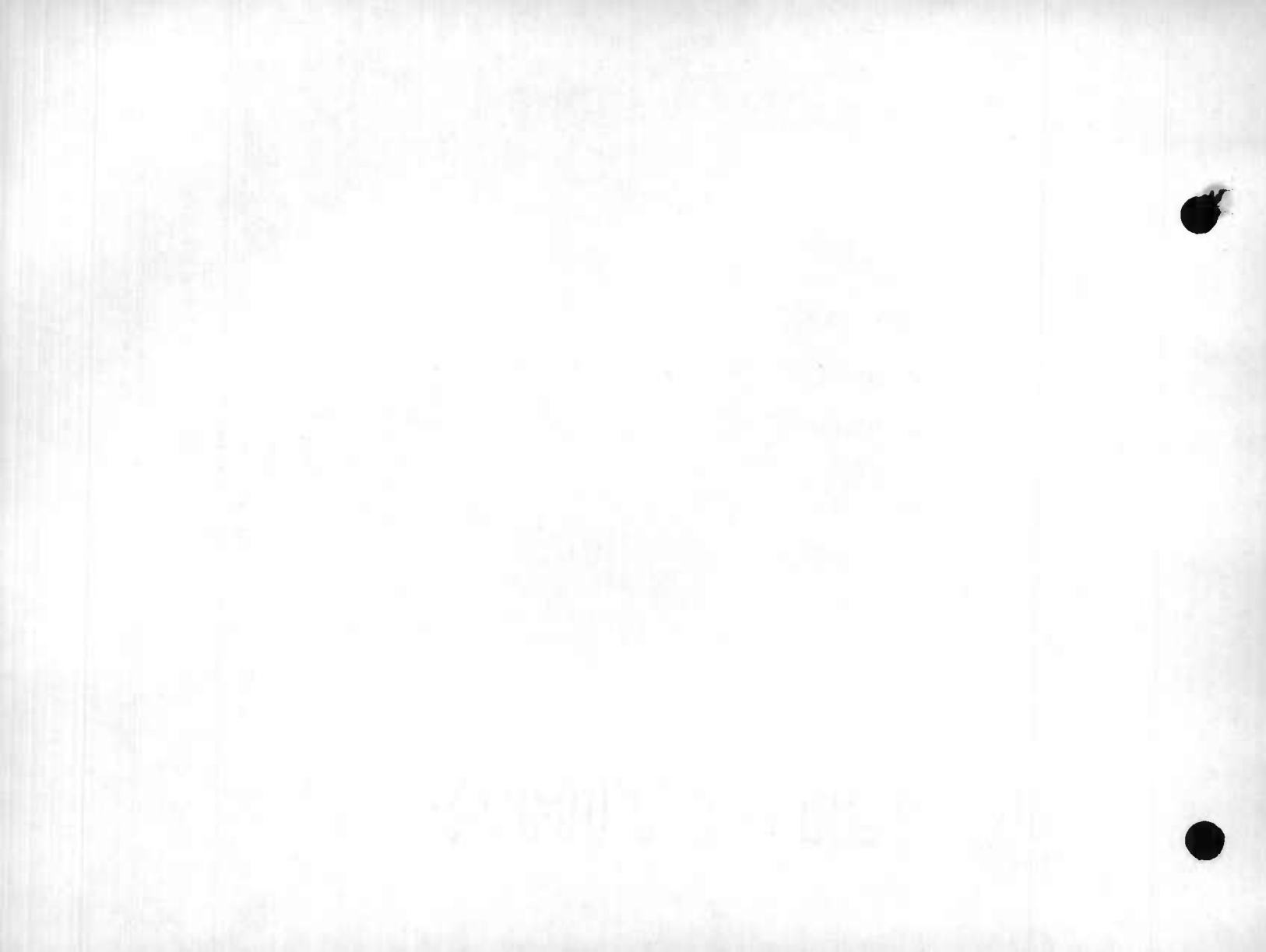
NAME: Rose Papa

DATE OF DEATH: January 27, 1979

PLACE OF DEATH: Baltimore City

SEE: # 79-03944  
February, 1979  
Baltimore City





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01224

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
SALVATORE						PAPA		January 25, 1979				9:00 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR June 5, 1893				85				MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Italy		U S A						Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		709 Stamford Road						Barber				Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland						Baltimore				709 Stamford Road			
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE LAST	
Vincent						Papa		Maryann				Carnaggio	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS					
no		216-32-B497A		Mrs. Genevieve McCloskey, 607 Wallerson Rd.				21228					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Cardio Vasc. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
												20 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <u>1-12</u> , 19 <u>59</u> , to <u>1-25</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
<u>Harry L. Knipp</u>		MD.								1/26/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Dr. Harry L. Knipp		5411 Old Frederick Rd., Balto., Md				26229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1/29/79		New Cathedral Cemetery		Baltimore, Maryland							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
1630 Edmondson Ave., Catonsville, MD		JAN 26 1979				<u>Henry McCloskey</u>							
Witzke Funeral Home of Catonsville, P.A. 21228													

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U.S. AIR FORCE

*[Faint, mostly illegible handwritten text across the page]*



Items 1,8 g528 2/9/79 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01225

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Willie M. Parham</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 30 79</b>			2b. HOUR M <b>M</b>	
3 SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 23 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5104 Laurel Ave</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nelson Parham</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Trusty</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-18-9234</b>		17. INFORMANT ADDRESS <b>Lindsay Parham 1805 Colmar Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>coronary artery disease</b> (c) <b>hypertension</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Susan Dexman M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/31/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Denman</b>				22e. ADDRESS <b>Balt City Hsp. Balt Md 21224</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Thomasburg Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Hofsky/Kelso</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28-01552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01226

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CHARITY PARKER		2a. DATE OF DEATH MONTH DAY YEAR 1-30-79		2b. HOUR 11A M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 21 06		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSP. 730 ASHBURTON ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN CITY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-03-5796	
17. INFORMANT ADDRESS 1239 Linwood Ave		17. INFORMANT Mrs. Ernestine Lewis		17. INFORMANT 2124		17. INFORMANT 2124	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intracerebral hemorrhage</u> 431- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Due to, or as a consequence of</u> (c) <u>Due to, or as a consequence of</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic heart disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> , 19 <u>78</u> , to <u>Jan 30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Jan 30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Araya Chansanchai M.D.				DEGREE M.D.		22c. DATE SIGNED 1/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARAYA CHANSANCHAI				22e. ADDRESS Lutheran Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-5-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME Joseph L. Reuss				24. FUNERAL DIRECTOR ADDRESS 2222 W. North Ave		25. DATE REC'D. BY REGISTRAR FEB 8 1979	

93-01558

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10-22a Film G528 2/9/79 re DEPARTMENT OF HEALTH AND MENTAL HYGIENE										79-01227	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR			
FIRST MIDDLE LAST						DATE KNOWN OF DEATH		MONTH DAY YEAR		HOUR	
Daniel Harry Parker						1 13 19 79		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male		Black		9 12 1940		38 YRS.		MONTHS DAYS HOURS MIN		1 13 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10:22 PM	
Maryland		U. S. A.		WIDOWED		DIVORCED		Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore City		1100 Pennsylvania Avenue									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1100 Penn Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
William G. Parker				Hilda Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				213-26-2771				William Parker 4213 Penhurst Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus											
2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Thomas D. Smith				Deputy Chief				1/14/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Thomas D. Smith, MD				111 Penn St. Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				1/18/1979				Mt. Calvary Cemetery			
23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Baltimore Co., Maryland											
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
Wm. C. March F/H				1101 East North Avenue				JAN 22 1979			
								25b. REGISTRAR'S SIGNATURE			
								R. H. Smith			

28-01551

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, completed and filed in by the funeral director, page 1 should be detached for use as the return receipt permit. Then please remove certificate from papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other fatal condition, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01228			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
EDWIN Allan PARKER				JAN 30, 1979 735A			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Nov. 2, 1938		40 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto. Md.		USA				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		JOHNS HOPKINS HOSP.		Farmer			
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS	
Md.		Balto.				43 Cherry Hill Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Winslow H. Parker Sr.				Dorothy Girdwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		214-38-0443		Mrs. Dorothy G. Parker Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) brainstem hematoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) diabetes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 48 hours 33 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		19 P.M.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from January 28, 1979, to January 30, 1979, that (2) (we) last saw the deceased alive on January 30, 1979, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) (did not) view the body after death.							
22b. SIGNATURE DEGREE				22c. DATE SIGNED			
William Rennie MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				1/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
William Rennie				Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Feb. 2, 79		Druid Ridge Cem.		Pikesville, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Eline Funeral Home Reisterstown, Md. 21136				FEB 1 1979		Dorothy G. Parker	

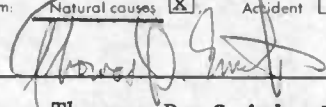

10-01558

EP 05 521 T 1001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM-17  
(VR A15 ME (5))  
30M 7/73

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01229 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Helen E. Parker</b>						2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> <b>1 2 19 79</b>		2b. HOUR <b>9:52 A M</b>			
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11/27/14</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>64</b> YRS.	IF UNDER 24 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>1 3 19 79</b>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>						
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>111 West Center Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>		13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>111 Centre St, Apt.1206</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Parker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Pearson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-05-6295</b>		17. INFORMANT ADDRESS <b>Waverly Lacy Parker P.O. Box Virginia</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy Chief</b>		MEDICAL EXAMINER		DATE SIGNED <b>1/4/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Charles A. rice</b>				ADDRESS <b>13005 Eutaw Place</b>		25a. DATE RECEIVED BY REGISTRAR <b>JAN 9 1979</b>		25b. REGISTRAR'S SIGNATURE 			

93-01552

ETRE BAC

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01230

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

J. Wilmer

Parker

2a. DATE OF DEATH

1-23-79

2b. HOUR

6:45 PM

3. SEX

Male

4. RACE

Negro

5. DATE OF BIRTH

6 13 1905

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore

Cite MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Provident Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY

13c. CITY OR TOWN  
Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4915 The Alameda

14. FATHER'S NAME

FIRST MIDDLE LAST

Ernest Parker

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST

Alwilda Mortimore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

214-12-2356

17. INFORMANT

ADDRESS

Juanita Webb 4915 The Alameda

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

185-

IMMEDIATE CAUSE (a)

Cardio pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

Ca. of prostate with metast

DUE TO, OR AS A CONSEQUENCE OF

(c)

Taxis to Brain Bone

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (we) (this hospital) attended the deceased from 1-18-1979 to 1-23-1979, that (I) (we) lost  
saw the deceased alive on 1-23-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

H. Devadoss

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

1-23-79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

H. Devadoss

22e. ADDRESS

Provident Hospital

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

1/27/1979

23c. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

23d. LOCATION

Baltimore, Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H 1101 East North Ave.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

JAN 25 1979

25b. REGISTRAR'S SIGNATURE

[Signature]



58-01530

100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01231 REG. NO.	
1- STATE REGISTRAR					1 DECEASED NAME (TYPE OR PRINT) <b>HARLAN I. PARKERSON</b>					2a DATE OF DEATH MONTH DAY YEAR <b>1-19-79</b> 2b HOUR <b>120 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 20 02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b KIND OF BUSINESS OR INDUSTRY		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		12c	
13a STATE <b>Maryland</b>		13b COUNTY <b>Carroll</b>		13c CITY OR TOWN <b>Woodbine</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>2116 Gillis Falls Road</b>		14 FATHER'S NAME FIRST MIDDLE LAST <b>James Edward Parkerson</b>	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Polly Anna Glover</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>314-05-7974</b>		17 INFORMANT ADDRESS <b>Marie L. Detweiler, Same As #13</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> 586- DUE TO, OR AS A CONSEQUENCE OF (b) <b>UREMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from <b>1/18/79</b> , 19____, to <b>1/19/79</b> , 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>J.H. JOSHIMD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>1/19/79</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.H. JOSHIMD</b>		22e ADDRESS <b>ST AGNES HOSPITAL</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1-23-1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Riverside</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Berrien, Michigan</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>Charles W. Burrier, Jr., Sykesville, Md.</b>			
25a DATE REC'D. BY REGISTRAR <b>JAN 24 1979</b>		25b REGISTRAR'S SIGNATURE <b>Robert McBratney</b>									

BP \_\_\_\_\_

18-01531

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01232

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDNA F. PARKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 17, 1979</b>			2b. HOUR <b>M</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 27, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>71</b>		8. UNDER 72 HRS HOURS MIN. <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accounts Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>			
13a. STATE <b>Maryland</b>						13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Frey</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine W. Frey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-05-2303</b>		17. INFORMANT ADDRESS <b>Patricia A. Smith 2501 Emmorton Road Abingdon, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular</u> 402- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ear disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>many years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Emphysema, Diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>61</u> , to <u>1/17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Hans J. Koetter</u>						DEGREE		22c. DATE SIGNED <u>1/18/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hans J. Koetter, M.D.</b>						22e. ADDRESS <b>7600 Osler Drive Towson, Md. 21204</b> <del>1900 E. Northern Parkway</del>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 20, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <u>Hickory McCready</u>			

28-01535

Oct. 15, 1907

A.B.A.

NEW YORK

1200 White Ave.

California

San Francisco

John

27-0-1-250

on

Marshall

William

Edward

John

James

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMM - 17  
(VR A15 ME (1))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 79-01233

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Rex Lee Parsons					ESTIMATED		1	8	19 79	M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
male	white	Oct. 14, 1920		58 YRS.			1		8	19 79		7:36 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		USA				Baltimore City MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Mercy Hospital				Laborer		const.				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2935 Lochary Road				
Maryland		Harford		Bel Air								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST		
Charlie		--		Parsons		Betty		--		Hash		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes					WWII		246-01-9353 Samuel L. Ellis, Bel Air, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				
				Assistant				1/9/79				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Ann M. Dixon, M.D.				111 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		Jan. 11, 1979		Holly Hill Mem Gard		White Marsh-Balto-Md.						
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Howard K. McComas III, Abingdon, Md.				JAN 11 1979								

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18-01533



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01234 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIS C. PARSONS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>(Jan.) 1-17-79</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-11-85</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>n/a</b> 13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mack Parsons</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fiorence E. Colleg</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>236-14-6307</b>		17. INFORMANT ADDRESS <b>Mrs. Gloria Donaldson Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>total bowel obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>carcinoma of colon</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>1-16-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bowel obstruction secondary to carcinoma of colon</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>4 January 1979</b> to <b>17 January 1979</b> , that (I) lost saw the deceased alive on <b>17 January 1979</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) view the body after death.							
22b. SIGNATURE <b>Anne P. Denham M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-17-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANNE P. DENHAM, M.D.</b>				22e. ADDRESS <b>3001 S. Hanover St Baltimore, Md 21230</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 20 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arnettsville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arnettsville, West Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>David F. Saunders</b> ADDRESS <b>Fairfax, Virginia</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>	

BP

72-01534



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01235

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NAOMI PATTERSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>01-12-79</b>		2b. HOUR <b>2 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 13 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic Help</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY PATTERSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>228-36-0189</b>		17. INFORMANT ADDRESS <b>Pepper Clark Pw. P.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN STEM STROKE</b> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 DAYS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>HYPERTENSION AND DIABETES MELLITUS</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (this hospital) attended the deceased from <b>DEC 28, 1978</b> to <b>JAN. 12, 1979</b> , that (we) lost saw the deceased alive on <b>JAN. 12, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Howard H. Gendason</b> MD.		22c. DATE SIGNED <b>JAN. 12, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWARD GENDASON MD.</b>		22e. ADDRESS <b>2025 W. FAYETTE ST. BALTO. MD. (21223)</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Flamengue</b>		23b. DATE <b>1/12/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fleming Plur</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGT. A.C.</b>
24. FUNERAL DIRECTOR NAME <b>135 3 91st St</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

78-01532

*Veronica*

1990

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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1990-1991

1871-1872

(Continued from page 7)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01236

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mitchell W. PAWLOWSKI</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 1, 1979</b> |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 1, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Marine Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Maritime</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS<br><b>1543 Elrino Street</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stanley Pawlowski</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(Unknown)</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT<br>ADDRESS<br><b>Mildred Pawlowski 1534 Elrino St. 21224</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3989 Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Rheumatic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>July</b> , 19 <b>68</b> , to <b>Dec</b> , 19 <b>78</b> , that (2) we lost<br>saw the deceased alive on <b>Dec 29</b> , 19 <b>78</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above; (3) we (did) not view the body after death.                                  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Ronald Gillilan</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   |   |  |  |  | 22c. DATE SIGNED<br><b>Jan 2, 1979</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RONALD GILLILAN</b>  |  |   |   | 22e. ADDRESS<br><b>U.S.P.H.S. Hospital Baltimore, Maryland</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan 5, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Brothers, Inc.</b>   |  |   |   | ADDRESS<br><b>7110 Belair Rd. 21206</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Timothy Helms</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

78-01236

January 1, 1978

February 1, 1978

BY

January 1, 1978

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Bellevue City,

USA

Bellevue City,

Bellevue City, Washington

Bellevue City, Washington

Bellevue City,

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Bellevue City, Washington

January 1, 1978

January 1, 1978

January 1, 1978

Bellevue City, Washington



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |   |   |   |   |  |  |   | 79-01237<br>REG. NO.  |  |
|--|--|-------------------------|---|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>A/K/A Willie Frances Payne<br/>/ Kitty Florence Payne</b>   |  |                         |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 - 2 19 79</b> |  | 2b. HOUR<br><b>12:50 a.m.</b>                                     |   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 5 1912</b>       |   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>66</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                    |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 - 2 19 79</b>                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2044 E. Baltimore Street</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                          |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>*-----</b>                                  |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         | 13b. COUNTY<br><b>-----</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 13e. STREET ADDRESS<br><b>2044 E. Baltimore Street</b>            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gilbert Monroe Earion</b>   |  |                         |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Lee Earion</b>  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |   |   | 17. INFORMANT<br><b>James Harry Payne</b>   |  |  | ADDRESS<br><b>21231<br/>2044 E. Baltimore St.</b>                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |   |   |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |   |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion depth resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |   |   |   |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><i>Hormez R. Guard</i>   |  |                         |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>                    |   |   |  | DATE SIGNED<br><b>1/2/79</b>   |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |                         |   | ADDRESS<br><b>111 Penn Street, Balto, MD 21201</b>          |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>cremation</b>   |  |                         | 23b. DATE<br><b>Jan 4, 79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemeteryn</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Brothers, Inc.</b>   |  |                         |   |   |   | ADDRESS<br><b>7110 Belair Rd. 21206</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1979</b>                       |   | 25b. REGISTRAR'S SIGNATURE<br><i>Henry K. Brady</i>                                 |  |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01238  
REG. NO.FOR  
1. STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Peter C. PEDERSEN</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>19</b> YEAR <b>79</b>   |  | 2b. HOUR <b>6:25</b> AM   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Mar.</b> DAY <b>22</b> YEAR <b>1899</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Norway</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General</b>            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-emp.</b>  |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Marcus</b> MIDDLE LAST <b>Pedersen</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ellen</b> MIDDLE LAST <b>?</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-7957</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Pauline Pedersen Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Congestive Failure</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Renal Failure</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/5/78</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Marcos B. Galicia Jr.</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/19/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCOS B. Galicia Jr.</b>   |  | 22e. ADDRESS<br><b>10 North Charles Gen. Hosp.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/22/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Kelly</b>  |  |  |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18-01538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the physician, it should be detached for use as the basis for preparing the death certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. The medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01239  
REG. NO.

|  |  |   |  |  |  |  |  |   |  |   |  |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLOTTE M. PEEPLES</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 10 79</b>  |  |  | 2b. HOUR<br><b>7:15 a</b><br>M   |  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 13, 1942</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>36</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b> |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |   |  |
| 13. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |   | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b>   |  |   | 16. KIND OF BUSINESS OR INDUSTRY<br><b>Social Secur.</b>   |   |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE <b>Maryland</b> 17b. COUNTY <b>Baltimore</b> 17c. CITY OR TOWN <b>Baltimore</b>  |  |   |  |  |  | 18. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   | 19. STREET ADDRESS<br><b>3438 Abbie Place 21207</b>  |   |  |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Smith, Sr.</b>  |  |   | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cecelia A. Goddard</b>   |  |  |  |  |   |  |   |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 23. SOCIAL SECURITY NO<br><b>215-40-6132</b>   |  |  | 24. INFORMANT ADDRESS<br><b>Mr. James A. Peebles, Same as above</b>  |  |   |  |   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <b>Aspiration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>c) <b>Metastatic Carcinoma of Breast</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1° 15'</b><br><b>11/76</b> |  |   |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Nausea + Vomiting</b>   |  |   |  |  |  |  |  |   |  |   |  |
| 26a. DATE OF OPERATION   |  |   | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 27a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   | 27b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 28b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 29a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 29b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 29c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 30. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> , 19 <b>79</b> , to <b>1/10</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/9/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |   |  |
| 31a. SIGNATURE<br><b>Paul D. Scanlon</b>   |  |   | 31b. DEGREE<br><b>M.D.</b>   |  |  | 31c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 31d. DATE SIGNED<br><b>1/10/79</b>   |   |  |
| 32a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul D. Scanlon</b>  |  |   | 32b. ADDRESS<br><b>Johns Hopkins Hosp Dept Medicine Balto</b>  |  |  |  |  |   |  |   |  |
| 33a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 33b. DATE<br><b>Jan. 13, 1979</b>  |  |  | 33c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  |   | 33d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   |  |
| 34. FUNERAL DIRECTOR<br>NAME<br><b>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |  |   |  |  |  | 35. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1979</b>   |  |   | 36. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |

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28-01538

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

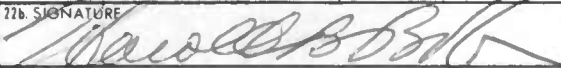

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 79-01240<br>REG. NO.  |   |
|---|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Petronilla (BETTY) (Bettie) PELIKAN</b>  |  |   | JANUARY 19, 1979   |   | 2b. HOUR<br>1:40 PM<br>XX XX XX   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 12, 1908   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                     |   |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balt., Md.   | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Legal Secretary             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Law Firm                                     |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY ---- 13c. CITY OR TOWN Baltimore   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>509 N. Belnord Avenue                                      |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Pelikan   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Magdalen ?                                     |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----<br>220-07-5828  | 17. INFORMANT Baltimore, Maryland, 21202<br>John T. Coady- 101 E. Redwood St.                |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE<br>2500 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DIABETES MELLITUS |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 WEEK<br>YEARS   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) this hospital attended the deceased from 1-14 19 79 to 1-19 19 79, that (I) (we) most saw the deceased alive on 1-19 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)                                 |  |   |  |   |   |
| 22b. SIGNATURE<br>A. F. Nazemi M.D.   |  |   |  | 22c. DATE SIGNED<br>1-19-79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. F. NAZEMI, M.D.   |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD     |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/22/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery-Baltimore, Md.       |   |
| 24. FUNERAL DIRECTOR NAME<br>John A. Moran, Inc.<br>3000 E. Baltimore St.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>P. A. [Signature]                                   |   |

79-01540



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |                         | REG. NO. 79-01241  |  |
|--|--|---|--|---|--|--|--|---|-------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | I DECEASED NAME (TYPE OR PRINT) <b>Agnes F. PENDERGAST</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>January 8 1979</b>                                       |  |   | 2b. HOUR <b>1:25P M</b> |  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>June 15, 1888</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS   |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |                         | 8 IF UNDER 24 HRS HOURS MIN.                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                |  |   |                         |  |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                         |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>763 Grantley Street</b>  |                         |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Martin Pendergast</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Shaffer</b>  |  |  |  |   |                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO   |  | 17 INFORMANT <b>Calvert &amp; Fayette Robert P. Conrad, Suite 200 Equitable Bldg.</b>        |  |   |                         |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pneumonia With Sepsis</b>  |  |   |  |   |  |  |  |   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> |  |
| 486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |  |  |   |                         |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |  |  |   |                         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Congestive Heart Failure</b>   |  |   |  |   |  |  |  |   |                         |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |                         |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |                         |  |  |
| 22a. I certify that <del>XXXXXX</del> attended the deceased from <b>January 4</b> 19 <b>79</b> , to <b>January 8</b> 19 <b>79</b> , that <del>XX</del> <input checked="" type="checkbox"/> saw the deceased alive on <b>January 8</b> 19 <b>79</b> , and that in <del>XX</del> <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above <del>XXXX</del> (I did <del>XXXX</del> view the body after death). |  |   |  |   |  |  |  |   |                         |  |  |
| 22b. SIGNATURE    |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>1-8-79</b>  |                         |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold B. Bob, M.D.</b>   |  |   |  | 22e. ADDRESS <b>c/o Maryland General Hospital</b>   |  |  |  |   |                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/12/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>    |  |   |                         |  |  |
| 24 FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville, P.A.</b> ADDRESS <b>1630 Edmondson Ave., Catonsville, MD</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE         |                         |  |  |

18-01541



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01242  
REG. NO.

|  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a DATE OF DEATH  |  |  | MONTH DAY YEAR  |  |  | 2b HOUR                                   |  |  |
| MARY E. PERCY  |  |  |   |  |  | 1 25 79   |  |  |   |  |  | 3:50A AM                                  |  |  |
| 3 SEX  |  |  | 4 RACE  |  |  | 5 DATE OF BIRTH   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |  | 7a IF UNDER 1 YEAR                        |  |  |
| Female   |  |  | White   |  |  | MONTH DAY YEAR  |  |  | 72 YRS.   |  |  | MONTHS DAYS HOURS MIN                     |  |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7c CITIZEN OF WHAT COUNTRY?   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |   |  |  |
| Maryland   |  |  | U.S.  |  |  |   |  |  | BALTIMORE CITY MD.  |  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |  |   |  |  |
| BALTIMORE  |  |  | ST AGNES HOSPITAL   |  |  | Housewife   |  |  |   |  |  |   |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b COUNTY  |  |  | 13c CITY OR TOWN  |  |  | 13d INSIDE CITY LIMITS?   |  |  | 13e STREET ADDRESS                        |  |  |
| Maryland   |  |  | Baltimore   |  |  | Baltimore   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 3 N. Beechfield Ave.                      |  |  |
| 14 FATHER'S NAME   |  |  | 15 MOTHER'S MAIDEN NAME   |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b SOCIAL SECURITY NO.   |  |  | 17 INFORMANT ADDRESS                      |  |  |
| Charles  |  |  | Grace   |  |  | no  |  |  | 220-09-0387   |  |  | Margaret Carvajal, 152 Hopkins Road 21212 |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bacterial sepsis + shock</u><br>5680<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Infarcted Small bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>peritoneal adhesions</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>several days</u><br><u>years</u> |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?  |  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |  |   |  |  |
|  |  |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |   |  |  |
|  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 22a I certify that (a) (this hospital) attended the deceased from <u>4/24/79</u> 19 <u>79</u> to <u>4/25/79</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>4/25/79</u> 19 <u>79</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (1) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.                      |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 22b SIGNATURE  |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  |  | 22c DATE SIGNED   |  |  |   |  |  |
| <u>Robert E. Cranley, Jr.</u>  |  |  | MD  |  |  |   |  |  | <u>4/25/79</u>  |  |  |   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e ADDRESS   |  |  |   |  |  |   |  |  |   |  |  |
| CRANCEY, R. E.   |  |  | ST AGNES HOSP   |  |  |   |  |  |   |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b DATE  |  |  | 23c NAME OF CEMETERY OR CREMATORY   |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |  |  |   |  |  |
| Burial   |  |  | 1/29/79   |  |  | Baltimore Nat'l Cem.  |  |  | Baltimore, Maryland   |  |  |   |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  | 1630 Edmondson Ave., Catonsville Md   |  |  | 25a DATE REC'D. BY REGISTRAR  |  |  | 25b REGISTRAR'S SIGNATURE   |  |  |   |  |  |
| Witzke Funeral Home of Catonsville, P.A.   |  |  | 21228   |  |  | JAN 26 1979   |  |  | <u>Robert E. Cranley, Jr.</u>                                       |  |  |   |  |  |

18-01545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |                   |  |  | 79-01243   |  |
|---|--|---|--|--|--|--|-------------------|--|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  |  |  |  |                   |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>STELLA May PERKINS   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/1/79                   |  | 2b. HOUR<br>Sep M |  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-30-1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS  |                   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD                         |                   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK NURSING HOME |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SPEECH TEACHER |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BALTIMORE                                       |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |  |  |  |  |                   |  |  | 13b. COUNTY  |  |
| 13c. CITY OR TOWN<br>SALISBURY  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  | 13e. STREET ADDRESS<br>415 PINEHURST AVEUNE  |  | 21801  |                   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Luther PERKINS MD  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORENZA Shultz |  |                   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>214-40-5248   |  | 17. INFORMANT<br>ADDRESS<br>KESWICK 700 W. 40th STREET 21211   |  |  |                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic carcinoma<br>1990<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |  |                   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 months   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |  |                   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |                   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                   |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 9/18/78, 19, to 1/1/79, 19 79, that (I) (we) saw the deceased alive on 1/1/79, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |                   |  |  |  |  |
| 22b. SIGNATURE<br>A. Allan Spier MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  |  |                   | 22c. DATE SIGNED<br>1/1/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. ALLAN SPIER   |  |   |  | 22e. ADDRESS<br>700 W. 40th St. BALTIMORE  |  |  |                   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>1/4/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Central Cemetery                             |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>New London Frederick Co. Md            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee Funeral Home   |  |   |  | 3631 Falls Road 21211  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1979  |                   | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

10-01513

10-01513

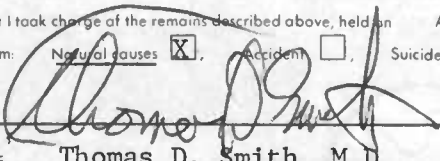

10/19

Control Country

New London Properties Co.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |   |   |   |   |  | 79-01244<br>REG. NO. |  |
|---|-------------------------|--|--|---|---|---|---|---|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harry Perlman</b>   |                         |  |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 10 1979</b>         |   | 2b. HOUR<br><b>M</b>                                      |  |                      |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 31, 1904</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>74</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | 7c. DATE PRONOUNCED DEAD<br><b>1 10 1979</b>                                  | 2d. HOUR<br><b>9:50A</b>  |   | M   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |   |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CITY OF BALTO.</b>                          |   |  |                      |  |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |   | 13e. STREET ADDRESS<br><b>602 S. SMALLWOOD ST. #21223</b> |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HYMAN PERLMAN</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>YETTA UNKNOWN</b>   |   |   |   |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>SAMUEL PERLMAN 602 S. SMALLWOOD ST. #2122</b>   |   |   |   |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |  |   |   |   |   |   |  |                      |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |   |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |   |   |   |   |   |  |                      |  |
| ACTUAL SIGNATURE<br>   |                         | TITLE (SPECIFY)<br><b>Deputy Chief</b>   |  |   |   | DATE SIGNED <b>1/10/79</b>  |   |   |  |                      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St. Balto., Md.</b>   |  |   |   |   |   |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>JAN. 12, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOGAN ABRAHAM</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MARYLAND</b>                                       |   |   |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>1601 REISTERSTOWN RD., BALTO., MD 21215</b>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br> |   |   |  |                      |  |



44510-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01245  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELIZABETH PERRY</b>   |  |  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 21 1979</b>   |  | 2b. HOUR<br><b>8:50P<sub>M</sub></b>   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-14-1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAID</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOTEL</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1115 ENSOR ST</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEO White</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PEARL Austin</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>230-12-4322</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Philip Spencer 1115 Ensor St</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CP arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Extreme debility and terminal state</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Widely metastatic Colon Ca</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~ 2 mos</b><br><b>~ 2 yrs</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>4/77</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colon Carcinoma</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3<sup>rd</sup> 4/21</b> , 19 <b>79</b> , to <b>8<sup>th</sup> 4/21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8<sup>th</sup> 4/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>P. Campochiano</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/21/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. Campochiano</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/25/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A. A. County Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Locks Funeral Home</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Delaney</b>   |  |

BP

73-01542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |   | 79-01246<br>REG. NO.                                |   |                              |                          |  |
|--|--|---|--|---|---|--|--|--|---|---|---|------------------------------|--------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Angelo Pezzella</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-16-79</b>  |   |                              | 2b. HOUR<br><b>6PM</b> M |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 16 02</b>  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS                                   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                      |   | IF UNDER 24 HRS<br>HOURS MIN |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sicily</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                            |  |   |   |   |                              |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>H. Kohn</b> |   |                              |                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   |  |   | 13b. COUNTY<br><b>Harford</b>   |  | 13c. CITY OR TOWN<br><b>Fallston</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>21047 Md. 2005 Angleside Rd. Fallston</b> |                              |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Flippo Pezzella</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Giuseppa Mafaraci</b>   |  |  |  |   |   |   |                              |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-24-1674</b>  |  | 17. INFORMANT<br><b>Son-P. Michael</b>  |   |  |  | ADDRESS<br><b>(Same)</b>   |   |   |   |                              |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br><b>3352</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>lung &amp; liver lateral sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |   |                              |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |   |  |  |  |   |   |   |                              |                          |  |
| 19a. DATE OF OPERATION<br>____   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>____  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |                              |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>____ P.M. 19 ____  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>____  |   |  |  |  |   |   |   |                              |                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>____  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>____   |   |  |  |  |   |   |   |                              |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> 19 <b>79</b> , to <b>1/16</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/16</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |   |  |  |  |   |   |   |                              |                          |  |
| 22b. SIGNATURE<br><b>BA Silver</b>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |   | 22c. DATE SIGNED<br><b>1/16/79</b>                  |   |                              |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BA Silver</b>  |  |   |  |   | 22e. ADDRESS<br><b>Good Samaritan</b>   |  |  |  |   |   |   |                              |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-20-1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Belair Memorial Gar.</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Belair Harford Md.</b>            |  |   |   |   |                              |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.F. Lassam, 11750 Belair Rd. Kingsville, Md. 21087</b>   |  |   |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1979</b>                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. McCready</b>   |   |   |                              |                          |  |

10-01548

BP

DHMM - 16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, regardless of whether the body is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 79-01247<br>REG. NO.  |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Burton Cunningham Phelps</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>January 12, 1979</b>                          |  |  |  | 2b. HOUR<br><b>a. m.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>April 2, 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Saint Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bridge Construction</b>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  |   |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Linthicum Heights</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Burton Phelps</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irene Cunningham</b>             |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WW 2</b>  |  | 17. INFORMANT<br><b>Regina T. Phelps</b>  |  | ADDRESS<br><b>Same as #13</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>10:45 AM</b>               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diabetes Mellitus and Paraplegia to Thoracic Intercostal Thrombosis</b>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>11:00 AM</b> , 19 <b>78</b> , to <b>8:00 AM</b> , 19 <b>79</b> , that (II) (we) last saw the deceased alive on <b>8:00 AM</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.                               |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Arthur A. Siebens</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/15/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur Siebens, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Good Samaritan Hospital, 5601 Loch Raven Blvd.</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/16/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b>    |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McCully F.H. Mtn. &amp; Tick Neck Rds.; Pasadena, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frederick McBrady</b>                               |  |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

| Item #188 Film G527 1/31/79 re  |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 79-01248  |  |
|---|--|---|--|--|--|---|--|
| 1. STATE REGISTRAR  |  | CERTIFICATE OF DEATH  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES EVERETT PHILLIPS, SR.</b>   |  |   |  | 2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>11</b> YEAR <b>1979</b>  |  | 2b. HOUR <b>10<sup>04</sup> A M</b>   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH <b>06</b> DAY <b>30</b> YEAR <b>07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>R.R. CLERK</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. CITY OR TOWN <b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS <b>400 MONTEMAR AVENUE, 21228</b>   |  |
| 14. FATHER'S NAME FIRST <b>HARRY</b> MIDDLE <b>E.</b> LAST <b>PHILLIPS</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>WINNIE</b> MIDDLE <b>CHAMBERLINE</b> LAST <b>CHAMBERLINE</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>218-10-0841</b>  |  | 17. INFORMANT ADDRESS <b>BERNICE A. PHILLIPS, 400 MONTEMAR AVENUE</b>   |  |
| 18. IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b>  |  |   |  |
| 19. DUE TO, OR AS A CONSEQUENCE OF (b) <b>MARKED CORONARY ARTERY ATHEROSCLEROSIS</b>  |  |   |  |  |  |   |  |
| 20. DUE TO, OR AS A CONSEQUENCE OF (c) <b>410-</b>  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>James E. Taylor</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>1/11/79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES E. TAYLOR, M.D.</b>  |  |   |  | 22e. ADDRESS <b>ST AGNES HOSPITAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>01-13-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Patricia K. Brady</b>   |  |

84510-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items #23a-23d per phone call w/Fun State of Maryland  
FOR Home 1/9/79 rc  
1 - STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
79-01249  
REG. NO.

|   |  |  |   |   |   |  |  |  |
|---|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCES PHILLIPS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 1, 1979</b> |   |   | 2b. HOUR<br><b>2:50 M</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 26 04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Finishing Room</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Westvaco</b> |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |   | 13b. COUNTY<br><b>Allegany</b>  |   | 13c. CITY OR TOWN<br><b>Westernport</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James T. Crawford</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Thompson</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-05-9629</b>  |   | 17. INFORMANT<br><b>Mary R. Grove</b>   |   | ADDRESS<br><b>1114 Pratt Street<br/>Baltimore, Maryland</b>  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>brain stem stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mths</b> |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>staphylococcal pneumonia</b>   |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/24/78</b> to <b>1/1/79</b> , tho (I) (we) lost<br>saw the deceased alive on <b>1/1/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Peta J. Whitehouse MD</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/1/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter J. Whitehouse</b>   |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/5/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philof Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westernport Alleg. Co. Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Nancy W. Haight</b>  |  |  |   | 25. DATE REC'D BY REGISTRAR<br><b>1/1/79</b>  |   |  |  |  |
| 26. ADDRESS<br><b>Sylacville, Md.</b>   |  |  |   | 27. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |  |  |

28-01548

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |                            | 79-01250<br>REG. NO.                            |  |
|--|--|---|--|--|--|---|--|---|----------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Frederick W. PILGRIM</u>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>January 22 1979</u>                                   |  |   | 2b. HOUR<br><u>7:18A</u> M |   |  |
| 3 SEX<br><u>MALE</u>   |  | 4 RACE<br><u>white</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>May 9 1900</u>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>78</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                            | IF UNDER 24 HRS.                                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br><u>Md.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                                |  |   |                            |   |  |
| 10 CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Maryland General Hospital</u> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>LinoType</u>             |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><u>PRINTING</u>   |                            |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Md.</u>  |  | 13b. COUNTY<br><u>BALTO</u>   |  | 13c. CITY OR TOWN<br><u>PARKVILLE</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>3033 ACTON RD</u>   |                            |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>George Pilgrim</u>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Sophia Westendorf</u>  |  |  |  |   |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>212-10-3782</u>  |  | 17 INFORMANT<br><u>DORIS O PILGRIM</u>   |  | ADDRESS<br><u>SAME</u>  |  |   |                            |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>5602</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  |   |  |  |  |   |  |   |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Dehydration, Malnutrition</u>  |  |   |  |  |  |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION<br><u>1-18-79</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Volvulus</u>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |                            |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 11</u> 19 <u>79</u> , to <u>January 22</u> 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>January 22</u> 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (I) did not view the body after death. |  |   |  |  |  |   |  |   |                            |   |  |
| 22b. SIGNATURE<br><u>James R. Stone M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><u>1-22-79</u>  |                            |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>James R. Stone, M.D.</u>   |  |   |  | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>   |  |   |  |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>1-24-79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>PARKWOOD</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE MD</u>                               |  |   |                            |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>EVANS FUNERAL Chapel</u>   |  |   |  | ADDRESS<br><u>8800 HARTFORD RD</u>   |  | 25a. DATE REC'D BY REGISTRAR<br><u>JAN 25 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCready</u>   |                            |   |  |

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DHMH-16 20M  
(VRA 15, 4) 7/78

10-01520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |  |  |  |   | REG. NO. <b>79-01251</b>                           |  |
|--|--|---|---|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |  |  |  |  |  |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>2 ESTHER</b>   |  |   | FIRST <b>ALICE</b> MIDDLE <b>ESTHER</b> LAST <b>PILOT</b>           |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/7/79</b>                                  |  |  | 2b. HOUR<br><b>1A M</b>   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 27, 1919</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS                                    |  | IF UNDER 1 YEAR MONTHS DAYS                                      |   | IF UNDER 24 HRS. HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                    |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT AGNES HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beautician</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Personal Hyg.</b>        |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                     |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>604 Olesmont Road 21228</b>   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Louis Elwood Pattison</b>   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Helen Peters</b>  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>215-09-1302</b>                      |  | 17 INFORMANT ADDRESS<br><b>Mr. Oliver Pilot Same as # 13</b>   |  |  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br><b>1990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on _____, 19_____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. |  |   |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>D.E. Thweatt Jr. MD</b>   |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |   | 22c. DATE SIGNED<br><b>1/7/79</b>                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.E. Thweatt Jr. MD</b>  |  |   |   |  | 22e. ADDRESS<br><b>900 S. CATON AVE-BALTO., MD 21229</b>   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>1/9/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery Woodlawn</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Edw. S. MacNabb Sons, Inc.</b>   |  |   |   |  | ADDRESS<br><b>Catonsville, Md.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1979</b>              |   | 25b. REGISTRAR'S SIGNATURE<br><b>Pistroy Kelly</b> |  |

BP



78-01221



ALICE BATHS

Aug. 27, 1919

Memorandum

Female

BALTIMORE CITY

SAINT AGNES HOSPITAL

BALTIMORE

605 Lombard Road

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before

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Edward

Levin

211-22-1205

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300 E. CATON AVE-BALTO. MD 21203

NEW YORK, N.Y. 10011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | REG. NO. 79-01252                            |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
|  |  | Thomas J Pinkine, Sr.  |  |   |  | January 24, 1979  |  |  |  | 3:55 pm                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                              |  |
| Male   |  | White  |  | MONTH DAY YEAR<br>Sept 6 1923   |  | 55 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| Maryland   |  | U.S.A.   |  |   |  | Baltimore City  |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| Baltimore  |  | The Johns Hopkins Hospital   |  | Employee, J.H.  |  | N.A.S.A.  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| Va.  |  | Accomack   |  | Middletown  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Howard Pinkine  |  | FIRST MIDDLE LAST<br>Marjorie Bramble  |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |  |  |
| Yes  |  | WWII 216-18-4500   |  | Mrs. Maive Pinkine - Middletown, Va.  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.)   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>  |  |  |  |   |  |   |  |  |  | immediate                                    |  |
| 2880 DUE TO, OR AS A CONSEQUENCE OF -  |  |  |  |   |  |   |  |  |  | week   |  |
| (b) <u>pneumonia + heart failure</u>   |  |  |  |   |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  | 2 years                                      |  |
| (c) <u>chronic granulocytic anemia</u>   |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |  |  |
| <u>poor nutritional status</u>   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> limited |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED  |  |   |  |  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |   |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET  |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19</u> , 19 <u>79</u> , to <u>Jan 27</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |  |  |  |  |
| Martha L. Elks MD  |  |  |  |   |  | 1/24/79   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |  |  |  |  |
| Martha L. Elks   |  | Johns Hopkins  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | CITY OR TOWN   |  | COUNTY STATE                                 |  |
| Burial   |  | 1-28-1979  |  | Middletown Baptist  |  | Middletown  |  | Accomack Co.   |  | Va.  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |  |  |
| Archie Temperanceville, Jr.  |  | FEB 1 1979   |  | Marilyn M. Brady  |  |   |  |  |  |  |  |

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79-01525

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01253

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br><b>Henry P. Plein</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>January 21, 1979</b>   |   | 2b. HOUR<br><b>3:28</b> M.                              |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>March 2, 1908</b>  |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>City</b> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Caton Manor Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Truck Driver</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Elec. Power</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                | 13e. STREET AND NUMBER<br><b>1250 Grantley St.</b>  |   |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Joseph Plein</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Etta R. Self</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-03-5866</b>  |  | 17. INFORMANT<br>Address<br><b>Ellicott City, Md.<br/>Mr. Paul Plein 3100 N. St. Johns Lane</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic ethanolism with extensive neuropathy</b>   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                 |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13, 1978</b> , to <b>1/21, 1979</b> , that (I) (we) last saw the deceased alive on <b>1/21, 1979</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Herbert J. Levickas, M.D.</b>  |   | 22c. DATE SIGNED<br><b>1/23/79</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Herbert J. Levickas, M.D.</b>                                |   |
| 22e. ADDRESS<br><b>5404 East Drive</b>  |   | 22f. ADDRESS<br><b>(21227)</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/24/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |   | 23e. ADDRESS<br><b>21229</b>  |  | 23f. ADDRESS<br><b>21229</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab 3512 Frederick Ave.</b>   |   | 25a. RECEIVED BY REGISTRAR<br><b>JAN 26 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. J. Cuddy</b>  |   |

78-01523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified *immediately*.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | 79-01254<br>REG. NO.  |   |   |   |  |  |
|--|--|--|---|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR                                      |   |   |   |  |  |
| 3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Catherine L. Pletzer</i>  |  |  |   |   | 2b. HOUR M<br><i>Jan. 6, 1979</i>                                     |   |   |   |  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>June 14, 1910</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>68</i>                                 |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                 |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1603 Webster St. Balto. Md.</i> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  |  |   |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>                                 |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Henry P. Jackson</i>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Annie T. McLeavy</i> |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><i>212-74-1989</i>                        |   | 17. INFORMANT ADDRESS<br><i>Mr. George M. Pletzer, Jr.</i>            |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Failure</i><br><i>4409</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Generalized Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 yr.</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i> |  |  |   |   |   |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1, 1977</i> , to <i>1-6, 1979</i> , that (I) (we) lost saw the deceased alive on <i>1-6, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |   |  |  |
| 22b. SIGNATURE <i>A.C. Sollod</i> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |   |   | 22c. DATE SIGNED<br><i>1-8-79</i>   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A.C. SOLLLOD</i>   |  |  |   |   |   | 22e. ADDRESS<br><i>707 Fort Ave. Balto. Md. 21230</i>                             |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>Jan. 10, 1979</i>                                   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cent.</i>        |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i> |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>McAulley Funeral Home, 130 E. Fort Ave. Balto. Md.</i>   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1979</i>                                |   | 25b. REGISTRAR'S SIGNATURE<br><i>Lillian McLeavy</i>  |  |  |

78-01524





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | 79-01255<br>REG. NO.   |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>John CHARLES POETZEL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/02/79</b>  |  | 2b. HOUR<br><b>150P</b>  |
| 3 SEX<br><b>male</b>   | 4 RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 16, 1903</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti. City</b>                                      |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITALS</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BET. STEEL CO.</b>     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>610 S. EAST AVE. # 21224.</b>  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN POETZEL</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA</b>                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-1575A</b>  |   | 17. INFORMANT<br><b>3915 RIDGECROFT RD<br/>BARBARA A. MACK; BALTO., 21206, MD.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DOE TO, OR AS A CONSEQUENCE OF (b) _____<br>DOE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Lung Cancer</b>  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12/30</b> <b>78</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>78</b> , to <b>01/02</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>01/02</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.    |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Mark Hirsch Korn</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c. DATE SIGNED<br><b>01/02/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark Hirsch Korn</b>   |  | 22e. ADDRESS<br><b>Baltimore City Hosps</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-6-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEMETERY</b>                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>7401 GERMAN HILL RD., BA. CO., MD.</b>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles L. Zeller &amp; Son, Inc.</b>   |  | 901 S. CONKLING ST.<br>BALTO., 21224, MD.  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1979</b>                                |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Joseph M. Brady</b>   |  |  |   |  |  |

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Items #18-22a Film G529 3/6/79

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01256

REG. NO.

|  |  |  |  |   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
|--|--|--|--|---|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH                      |  | ESTIMATED                            |  | MONTH                          |  | DAY   |  | YEAR |  | 2b. HOUR |  |          |  |
| Douglas  |  | J.   |  | Pointer, Jr.  |  |   |  | 1   |  | 12                                   |  | 19                             |  | 79    |  |      |  | M        |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                                  |  | IF UNDER 24 HRS.                     |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY  |  | YEAR     |  | 7d. HOUR |  |
| Male   |  | Black  |  | 2/15/74   |  | 4 YRS.  |  |   |  |                                      |  | 1                              |  | 12    |  | 19   |  | 79       |  | 11:09P   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | #   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                |  |       |  |      |  |          |  |          |  |
| Md.  |  | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  |   |  | Baltimore City,                      |  |                                |  |       |  |      |  |          |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| Baltimore City   |  | 605 Park Avenue  |  |   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                             |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| Md.  |  | City   |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 605 Park Ave. Apt. 8                            |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 14. FATHER'S NAME  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME                        |  | FIRST                                |  | MIDDLE                         |  | LAST  |  |      |  |          |  |          |  |
| Douglass Pointer Sr.   |  |  |  |   |  |   |  | Leslie Anderson                                 |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| No   |  |  |  |   |  | Leslie Anderson 605 Park Ave. Apt. 8                                |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 9889   |  | Lacerated liver  |  |   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  |  |  | (b)   |  | Blunt trauma to abdomen   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
|  |  |  |  | (c)   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                            |  |  |  |   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE                                |  |                                |  |       |  |      |  |          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| ACTUAL<br>SIGNATURE  |  | TITLE (SPECIFY)  |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED  |  | 1/13/79   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS  |  | 111 Penn St.  |  | Balto., Md.   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| Thomas D. Smith, M.D.  |  |  |  |   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY  |  | STATE                                |  |                                |  |       |  |      |  |          |  |          |  |
| Burial   |  | 1/18/79  |  | Cedar Hill  |  | Brooklyn  |  | Md.   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |
| Charles A. Rice 1300 Eutaw Place   |  | JAN 16 1979  |  | Rickey McCreedy   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

58-01526

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 79-01257   |  |
|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mery F. Pollock</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 15, 1979</b>                       |  | 2b. HOUR<br><b>2:30 P M</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 28, 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b><br>YRS. MONTHS DAYS                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4420 Cedar Garden Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Saleslady</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis A. Fisk</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Lynch</b>                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>041-12-8333</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>4420 Cedar Garden Road 21229</b><br><b>Mr. Robert J. Pollock, Sr.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Colon - metastatic to liver</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1974</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Possible D.I.C.</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>73</b> , to <b>1/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James Nolan</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/16/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. James Nolan</b>  |  | 22e. ADDRESS<br><b>1 Mallow Hill Rd., Baltimore, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/18/79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>1630 Edmondson Ave. Catonsville, Md</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Kelly</b>   |  |
| 26. WITZKE FUNERAL HOME OF CATONSVILLE, P.A. 21228   |  |   |  |  |  |

MEDICAL CERTIFICATION

2541 BP

79-01227

January 18, 1979

F. Bellows

February 2, 1979

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01258  
REG. NO.1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>La Verne FRANCIS POTTER Sr.</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 28 79</b>  |  |  | 2b HOUR<br><b>10<sup>44</sup> P.M.</b>   |  |   |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 2, 1922</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>  |  |   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance--Public Works AA co.</b> |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a STATE<br><b>Maryland</b>   |  |  | 13b COUNTY<br><b>Anne Arundel</b>   |  |  | 13c CITY OR TOWN<br><b>Riviera Beach</b>   |  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John F. Potter</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Clark</b>  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, (NO OR UNKNOWN))<br><b>YES</b>                        |  |   | 16b SOCIAL SECURITY NO.<br><b>214-16-9391</b>  |  |
| 17 INFORMANT<br>ADDRESS<br><b>Mrs. Lola M. Potter Same as above #13e.</b>  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio - Resp. Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CA - lung &amp; metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                              |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>11/29</b> , 19 <b>79</b> , to <b>11/28</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>11/28</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |  |  |  |  |   |  |  |
| 22b SIGNATURE<br><b>J. Mendoza</b>   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  | 22c DATE SIGNED  |  |   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JESUS MENDOZA</b>   |  |  | 22e ADDRESS<br><b>900 S CATON AVE BALTO MD 21229</b>  |  |  |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b DATE<br><b>2/1/79</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Mc Cully Funeral Home of Pasadena</b>  |  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>Pasadena, Md. JAN 30 1979</b> |  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



79-01228

STANLEY

POTTER

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

OTHER

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1911-1912

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002 S CATON AVE BALTO MD 21202



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01259

REG. NO.

|  |  |   |   |   |   |  |
|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT POWELL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-29-79</b>             |   | 2b. HOUR<br><b>8:35 AM</b>                                    |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-7-09</b>  |   |  |
| 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>— —   |   | IF UNDER 24 HRS.<br>HOURS MIN.<br>— —   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BAKERTON</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>?</b>  |  |   |   |   |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>CITY</b> 13c. CITY OR TOWN <b>BAKTO. CITY</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1501 N. DUKELAND ST.</b>                                      |  |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? UNKNOWN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? UNKNOWN</b> |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-409-583</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>DUKELAND NURSING HOME</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>BILATERAL PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>486-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 DAYS</b> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1-26-79</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— — — — —</b>   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-26-79</b> to <b>1-29-79</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-29-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and) did not view the body after death.   |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Sujeta Sapsiri, M.D.</b>  |  | DEGREE<br><b>—</b>  |   | 22c. DATE SIGNED<br><b>1-29-79</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUJETA SAPSIRI, M.D.</b>   |  | 22e. ADDRESS<br><b>Lutheran Hospital of Maryland</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-6-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |  |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Pass</b>  |  | ADDRESS<br><b>2222 W. North Ave</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1979</b>  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>—</b>   |  |   |   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02510-05

AND  
MENTAL HYGIENE  
BIRTH

NOTE: THIS IS NOT A LEGAL DOCUMENT

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01260

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frances G. Preller</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 10 79</b> |   |  | 2b. HOUR<br><b>6:45A</b> M   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 16, 1895</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Receptionist</b>                                    |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Rowley</b>  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Rooney</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-26-8729A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Robert L. Preller 3213 Birchmede Dr,</b>   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Metastatic Colon Carcinoma</b>  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>1/13</b> , 19 <b>79</b> , to <b>11/10</b> , 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> I saw the deceased alive on <b>11/9</b> , 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Donald Barber</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/10/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SEIBERT</b>   |  |  |   | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/12/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. McCready</b>  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

73-01589



CONFIDENTIAL

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01261<br>REG. NO.   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DORIS MAE PREYOSTO</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 1 3 79</b>   |  |   |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 17 25</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Md. Hosp</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Baltimore</b> 13b COUNTY <b>Balto.</b>   |  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>8019 Gray Haven Rd</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry HARRY Stanciliff</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Gould Gould</b>   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>218-22-4969</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JUDY CARTER 8019 GRAY HAVEN RD.</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pulmonary insufficiency + dehydration</b><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cancer of the ovary</b>                                 |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>3 yr</b><br><b>3 yr</b>                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 18</b> , 19 <b>78</b> , to <b>JAN 3</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Susan Willard</b> DEGREE <b>MD.</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUSAN WILLARD</b>  |  |  |  | 22e. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/6/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDEN OF FAITHS</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CO. MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond H. Kaczorowski</b> ADDRESS<br><b>2525 Fleet St</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

10510-05





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH **79-01262**

|   |  |                      |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|----------------------|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |   |  |   |  |  |  | REC. NO. <b>79-01262</b>  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James F. Price Sr.</b>   |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>4</b> YEAR <b>19 79</b> 2b. HOUR <b>M</b> |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>14</b> YEAR <b>1918</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>60</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>   |  | IF UNDER 24 HRS.<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>1</b> DAY <b>8</b> YEAR <b>19 79</b>                    |  | 2d. HOUR <b>12:48</b> P. <b>M</b>            |  |  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2075 Woodbourne/at home</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>  |  |                      |  | 13b. COUNTY <b>-----</b>  |  |   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |
| 13e. STREET ADDRESS <b>2075 Woodbourne Avenue</b>   |  |                      |  | 14. FATHER'S NAME<br>FIRST <b>Arthur</b> MIDDLE <b>B.</b> LAST <b>Price</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Cockrill</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | (IF YES, GIVE WAR OR DATES) <b>WW II</b>  |  |   |  | 16b. <b>218-10-2323</b>  |  |   |  | 17. INFORMANT ADDRESS <b>Mr. James F. Price, Jr. 6519 Loch Hill Ct.</b>                      |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>402-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |  |                      |  |   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b>   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |   |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>1/9/79</b>  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street, Balto, MD 21201</b>   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |                      |  | 23b. DATE <b>1/10/79</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>          |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>   |  |                      |  | ADDRESS <b>1050 York Road</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1979</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |  |  |  |  |

50-01585



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 7/77  
(VR A 15 (4))

| 1. FOR STATE REGISTRAR  |                 | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 79-01263<br>REG. NO.   |                     |
|---|-----------------|--|--|--|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JAMES R. PRIDGEN   |                 |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>01-25-79 |  | 2b. HOUR<br>10 P.M. |
| 3 SEX<br>MALE   | 4 RACE<br>BLACK | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 23 28   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY, BALTIMORE MD.                          |                     |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT            |                     |
| 13a. STATE<br>MD.   |                 | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTO.                  | 13e. STREET ADDRESS<br>3010 BAKER ST.  |                     |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>RICHARD PRIDGEN  |                 | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY A. JONES  |  |  |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>UNKNOWN  |                 | 16b. SOCIAL SECURITY NO.<br>Z12-26-0774  |  | 17. INFORMANT ADDRESS<br>MEDICAL RECORDS.  |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 431- CEREBRAL INFARCT<br>DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS<br>2 DAYS |                 |  |  |  |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>SEVERE DIASTOLIC HYPERTENSION  |                 |  |  |  |                     |
| 19a. DATE OF OPERATION  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                 |  |  |  |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23, 19 79, to 1-25, 19 79, that (I) (we) lost saw the deceased alive on 1-25, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |                 |  |  |  |                     |
| 22b. SIGNATURE<br>Uscar E. Fernandez M.D.   |                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-26-79  |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>USCAR E. FERNANDINI M.D.   |                 | 22e. ADDRESS<br>2025 W. FAYETTE ST. BALTO. MD. 21223   |  |  |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                 | 23b. DATE<br>1/30/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat. Mem. Park                             |                     |
| 23d. LOCATION CITY OR TOWN<br>Laurel, Maryland  |                 | 23e. STATE<br>Maryland   |  |  |                     |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 East North Ave.  |                 | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1979   |                     |
|   |                 |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                     |

MEDICAL CERTIFICATION

BP

13-01583

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01264

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2b. DATE OF DEATH   |   | 2b. HOUR  |   |
| VICTOR W PRUSS   |   | JANUARY 8, 1979   |   | 4:15 P.M.   |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR   |   |
| MALE   | WHITE   | JUNE 16, 1908   | 70 YRS.   | IF UNDER 24 HRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |   |
| PITTSBURGH, PA.  | U.S.A.  |   | BALTIMORE CITY, MD.   |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |   |
| BALTIMORE, MD.   | 904 S. FAGLEY ST. # 21224   | RETIRED   | STEEL CO.   |   |   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |
| MD.  |   | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 904 S. FAGLEY ST. # 21224   |   |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  |   |   |   |   |
| JOHN PRUSS   | MARY MURAWSKI   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT   | ADDRESS   |   |   |
| NO   | 213-07-8428   | HELEN PRUSS   | 904 S. FAGLEY ST.<br>BALTO., 21224, MD.                             |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARCINOMA OF the LUNG   |   |   |   |   | 6 MONTHS  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)  |   |   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|  |   |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) <del>XXX</del> (hospital) attended the deceased from 4-25, 19-73, to 1-8, 19-79, that (I) <del>XXX</del> lost<br>saw the deceased alive on 1-8, 19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>XXX</del> (did) <del>XXXX</del> view the body after death. |   | 22b. SIGNATURE<br>Melito M. Torres  |   | 22c. DATE SIGNED<br>1-11-79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |   |   |   |
| MELITO M. TORRES   |   | 441 S. ELLWOOD AVE., BALTO., 21224, MD.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN                                       | 23e. COUNTY   | 23f. STATE  |
| BURIAL   | 1-11-79   | SACRED HEART CEM.   | 7401 GERMAN HILL RD.  | BA.   | CO.   |
| 24. FUNERAL DIRECTOR<br>NAME   |   | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE  |   |   |
| Charles S. Zieher + Son, Inc.  |   | JAN 16 1979   |   |   |   |

40510-07



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01265<br>REG. NO.  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>ASA CALVIN PUMPHREY  |  |  |  | 1 23 79 8:05 a  |  |   |  |
| 3. SEX Male  |  | 4. RACE Cauc   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 15 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>ST. AGNES HOSPITAL              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired operator   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Transit   |  |
| 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Ellicott City   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS 3140 West Spring Dr 21043   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>late Thomas Pumphrey  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>late Ella Upton   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 213 10 1458   |  | 17. INFORMANT ADDRESS<br>Mrs Melva Pumphrey 3140 West Springs Dr.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest - ARRYTHMIA</u><br>4414<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Targene</u> <u>Glen</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RESECTION AORTIC ANEURYSM</u> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>1-18-79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ABDOMINAL AORTIC ANEURYSM<br>COLECTOMY |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19____, to _____, 19____, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above <input checked="" type="checkbox"/> (we) did not view the body after death.                       |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Carlos A. Gonzalez MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1-23-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Gonzalez  |  |  |  | 22e. ADDRESS<br>900 CATON AVE, BALTIMORE MD 21229   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan 26, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glenhaven   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glenburnie Maryland  |  |
| 24. FUNERAL DIRECTOR<br>Harry H. Witzke Columbia Road  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Rickey McCreedy   |  |



78-01582

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

DATE

TIME

ST. AGNES HOSPITAL

X

X

X

XX

X

900 CATON AVE, BALTIMORE MD 21229

ST. AGNES HOSPITAL

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01266

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>MARIE P. PUMPIAN</i>            |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11/24/1979</i>   |  | 2b. HOUR<br><i>4:15</i> M                                 |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>W.H. Te</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 23 1903</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS.                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>BALTO. MD</i>                               | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO. City</i> MD        |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>NORTH CHAS. General Hosp.</i> |   | 12a. SUPERVISOR<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>XXXXXX</i>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>TELEPHONE CO.</i> |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   |   |   |  |   |
| 13a. STATE<br><i>MD</i>   | 13b. COUNTY<br><i>BALTO.</i>  | 13c. CITY OR TOWN<br><i>BALTO.</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXX | 13e. STREET ADDRESS<br><i>3418 ESSEX RD.</i> 21207                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>ALONZO R. PHIPPS</i>                           |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ELLA COO</i>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>           |   | 16b. SOCIAL SECURITY NO.<br><i>212-03-6998</i>  |   | 17. INFORMANT ADDRESS<br><i>GEORGE PUMPIAN 3418 ESSEX RD. #21207</i> |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>irreversible shock</i><br><i>5756</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>prob gangrenous Gall Bladder</i> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>36h</i><br><i>36h</i><br><i>?</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Hypoglycemia</i>   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>11/23</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/23</i> , 19 <i>79</i> , to <i>11/24</i> , 19 <i>79</i> , that (I) (we) lost<br>saw the deceased alive on <i>11/24</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |  |  |
| 22b. SIGNATURE<br><i>H. al...</i>  |  | DEGREE   |  | 22c. DATE SIGNED<br><i>1-24-79</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>H. al...</i>   |  | 22e. ADDRESS<br><i>North Charles General</i>                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>   |  | 23b. DATE<br><i>JAN. 26, 1979</i>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ARLINGTON (CHIZUK AMUND)</i>                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MARYLAND</i>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., INC.</i><br>NAME ADDRESS<br><i>6010 REISTERSTOWN RD., BALTO., MD 21215</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 30 1979</i>                                  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Fitzgerald</i>                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-01500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | 79-01267<br>REG. NO.  |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jessie P. Pyles   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 30, 1979                            |   | 2b. HOUR<br>9:51 AM  |
| 3 SEX<br>female   | 4 RACE<br>Cau   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 5 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Manager |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone Company   |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>City  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>211 Rodgers Forge Rd.   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard A. Portner  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theresa L. Small                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>212-05-1386   | 17. INFORMANT<br>ADDRESS<br>Mr. Thomas O. Nuttle 223 Hopkins Rd.                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410- DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HRS<br>4 yrs |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 21 Apr 1976 to 30 Jan 1979, that (I) (we) last saw the deceased alive on 30 JAN 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br>Richard A. Portner M.D.   |   |   |  | 22c. DATE SIGNED<br>30 JAN 1979   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |   |  | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>2/1/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore, Md.   |   | 23e. COUNTY<br>BALTIMORE  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME   |   |   |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 1 1979  |  |
| 46500 York Road   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

58-01561

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 79-01268   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Nadine  |  | MIDDLE<br>M.   |  | LAST<br>Raith  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 2, 1979   |  | 2b. HOUR<br>1:15A M  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 13, 1924   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                            |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3506 Milvale Road   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>late George Ritmiller   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Yox   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 14 5240   |  | 17 INFORMANT ADDRESS<br>Mrs. Roberta Kapraun 3506 Milvale Road 21207   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>Coronary Artery Disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>One Month<br>Unknown |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from December 24, 1978, to January 2, 1979, that (X) (we) lost saw the deceased alive on January 2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.                                      |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Mildred A. Kinghorn M.D.   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br>1-2-79   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mildred A. Kinghorn M.D.  |  |  |  | 22e. ADDRESS<br>c/o Maryland General Hospital  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>Jan. 3, 1979  |  | 23c. NAME OF CEMETERY OR CREMATION<br>Loudon Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry H. Witzke  |  |  |  | ADDRESS<br>Columbia Road Ellicott City   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1979  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

BP



88510-07

<http://www.elsevier.com/locate/jbiotec>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 79-01269  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN B. RAMPOLLA</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 14, 1979</b> |   |  | 2b. HOUR<br><b>1:30P</b> M   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 13, 1911</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Barber</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Barber</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>401 Bryanstone Rd.</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Agostino Rampolla</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flavia Trifelletti</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-32-0888</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>401 Bryanstone Rd.</b><br><b>Angelina Rampolla Owings Mills, Md. 21117</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Overwhelming pneumonia</b>  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b>  |  |
| 2028<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Lennert's lymphoma</b>  |  |   |  |  |  |   |  | 2 years  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 4, 1979</b> , to <b>January 14, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 14, 1979</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Renee A. Waschler</b>  |  |   |  | DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>1/14/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Renee A. Waschler, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 17, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore, Maryland</b>                                     |  | COUNTY STATE   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>H. J. Schmitt</b>   |  |   |  | ADDRESS<br><b>Owings Mills, Md.</b>  |  | 25a. DATE REG'D. BY REGISTRAR<br><b>JAN 17 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |  |

13-01568

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01270

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ELSIE Rasmers RANDALL  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-9-79 |  |  | 2b. HOUR<br>1:25 P.M.  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>2-4-1890   |  | 6 AGE (IN YEARS [LAST BIRTHDAY])<br>88 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK NURSING HOME |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>F. W. Rasmers  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>KATE Gross S.  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NA  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-03-1656  |  | 17 INFORMANT ADDRESS<br>KESWICK 700W, 40th STREET 21211  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>4 yrs |  |   |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 27 July 1976 to 9 Jan 1979, that (1) (we) lost<br>saw the deceased alive on 9 Jan 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death.               |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Deborah D. Richardson M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>9 Jan 1979   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>1/11/1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc. Balto., Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Rickey McCreedy  |  |

78-01510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 79-01271                            |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MAX G. RATHJE   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 18 79  |  | 2b. HOUR<br>7:20 P.M.   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 8 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Germany   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Musician, Peabody |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Book Shop  |  |  |  |
| 13a. STATE<br>Maryland   |  |  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Karl ----- Rathje   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Betty ----- Unknown  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1282 Walker Ave. Balto.                                     |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>11-12-2915   |  | 17. INFORMANT<br>Mrs. Janie V. Rathje, Same as above  |  | ADDRESS  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4349<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>POSSIBLE INFECTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>URINARY TRACT INFECTION</u> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION<br>1/9/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/4</u> , 19 <u>79</u> , to <u>1/18</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  | 22c. DATE SIGNED<br>1/18/79                  |  |
| 22b. SIGNATURE<br>S. Scalina   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. SCALINA  |  |  |  | 22e. ADDRESS  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 22, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Co. Maryland          |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Petry, Helmut  |  |   |  |  |  |

15510-05

VOIDED #79-01272 SEE FEB., 1979 DEATHS

WILLIAM N. RAUSCH, 2/18/79, CITY





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 79-01273<br>REG. NO.  |                                    |  |  |  |  |
|--|--|--|--|---|--|---|------------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THELMA Mae RAWLINGS</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 21, 1979</b> |   |                                    |  | 2b. HOUR P <b>4:32 M</b>   |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b><br><del>Negro</del>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>9 17 1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.                                    |                                    | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                    |                                    |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>  |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN <b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS <b>3501 Woodlea Avenue</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST               |   |                                    |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Lee</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. <b>214-24-4187</b>   |  | 17. INFORMANT ADDRESS <b>Lillian Luttrell 4902 Beaufort Ave.</b>                  |                                    |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b>  |  |  |  |   |  |   |                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <b>septic shock</b>  |  |  |  |   |  |   |                                    |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <b>severe metabolic acidosis</b>   |  |  |  |   |  |   |                                    |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>severe coronary artery disease, right ventricular rupture</b>   |  |  |  |   |  |   |                                    |  |  |  |  |
| 19a. DATE OF OPERATION <b>12/30/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary artery disease</b>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                    |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |                                    |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3/79</b> , 19 <b>79</b> , to <b>1/21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |                                    |  |  |  |  |
| 22b. SIGNATURE <b>Craig Dufresne</b>   |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |                                    | 22c. DATE SIGNED <b>1/21/79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CRIC DUFRESNE, MD</b>   |  |  |  | 22e. ADDRESS <b>544 601 North Broadway</b>  |  |   |                                    |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/24/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>  |  |   |                                    | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>  |  |  |  | ADDRESS <b>1101 East North Ave.</b>   |  |   |                                    | 25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                     |  |  |  |

10-01513



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                                   |  | REG. NO. <b>79-01274</b> |  |
|--|--|--|--|--|--|--|--|-----------------------------------|--|--------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |                                   | 2b. HOUR   |                          |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>JAMES RAY</b>  |  |  |  |  | January 21, 1979   |  | 12:22P   |                                   | M  |                          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR                |  | 8. IF UNDER 24 HRS       |  |
| Male   |  | Black  |  | February 13 1908   |  | 70 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                                   |  |                          |  |
| unknown  |  | unknown  |  | unknown  |  | Baltimore City MD.   |  |                                   |  |                          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                          |  |
| Baltimore  |  | Maryland General Hospital  |  |  |  | unknown  |  | unknown                           |  |                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13a. INSIDE CITY LIMITS?   |  | 13b. STREET ADDRESS  |                                   |  |                          |  |
| 13a. STATE   |  |  |  |  | 13c. CITY OR TOWN  |  | 1400 John Street 21217   |                                   |  |                          |  |
| 13a. Maryland  |  |  |  |  | Baltimore  |  | 13c. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |                          |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |                                   |  |                          |  |
| FIRST MIDDLE LAST  |  |  |  |  | FIRST MIDDLE LAST  |  |  |                                   |  |                          |  |
| unknown  |  |  |  |  | unknown  |  |  |                                   |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |                                   |  |                          |  |
| unknown  |  |  |  |  | 220-07-5525  |  | Medical Record Address 21201   |                                   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |  |                                   |  |                          |  |
| IMMEDIATE CAUSE (a) <b>Sepsis</b>  |  |  |  |  |  |  |  |                                   |  |                          |  |
| 5990 DUE TO, OR AS A CONSEQUENCE OF <b>Infected Decubitus</b>  |  |  |  |  |  |  |  |                                   |  |                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  | (b) <b>Pneumonia</b>   |  |  |                                   |  |                          |  |
|  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF <b>Possible Urinary Tract Infection</b> |  |  |                                   |  |                          |  |
|  |  |  |  |  | (c) <b>Possible Urinary Tract Infection</b>                            |  |  |                                   |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |                                   |  |                          |  |
| <b>Dehydration, Adult Onset Diabetes Mellitus</b>  |  |  |  |  |  |  |  |                                   |  |                          |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                          |  |
|  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                   |  |                          |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |  |  |  |  |                                   |  |                          |  |
|  |  |  | P.M. 19  |  |  |  |  |                                   |  |                          |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |  |  | 21f. LOCATION  |  |                                   |  |                          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | STREET CITY OR TOWN COUNTY STATE   |  |                                   |  |                          |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 21, 1979</b> to <b>January 21, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 21, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |  |  |  |  |  |  |                                   |  |                          |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE   |  |                                   | 22c. DATE SIGNED   |                          |  |
| <b>James R. Stone M.D.</b>   |  |  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                   | 1-22-79  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS   |  |                                   |  |                          |  |
| <b>James R. Stone, M.D.</b>  |  |  |  |  |  | <b>c/o Maryland General Hospital</b>   |  |                                   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                     |  |  | 23d. LOCATION                     |  |                          |  |
| Removal  |  |  | 1/24/79  |  |  |  |  | CITY OR TOWN COUNTY STATE         |  |                          |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |                          |  |
| NAME ADDRESS <b>Antony Board 655 W. Balto. St. Balto., Md.</b>   |  |  |  |  |  | <b>JAN 26 1979</b>   |  |                                   | <b>Antony Board</b>  |                          |  |

78-01574

79 - 01275

VOID

WHITEFIELD

- \_\_\_ 6. we do not have sufficient information for a search. Please complete and return the enclosed application form together with the appropriate fee.
- \_\_\_ 7. You did not remit the required fee with your application. Please return the application with the proper fee.
- \_\_\_ 8. You failed to sign the enclosed check. Please sign it and return it together with the enclosed application form which you should complete.
- \_\_\_ 9. The issuance of an official transcript of a birth certificate or any information therefrom is restricted to the individual if of legal age or the parents whose names appear on the original record, or to a lawful representative of the registrant or to one or both parents.
- \_\_\_ 10. The issuance of an official transcript of a death certificate or any information therefrom is restricted to the family of the deceased, executor of the estate, or to a lawful representative of the deceased.
- \_\_\_ 11. The issuance of an official transcript of a marriage record or any information therefrom is restricted to the individuals named on the marriage certificate or to an attorney representing one of the parties to the marriage.
- \_\_\_ 12.

Sincerely yours,

*Pinkney McGready*  
Pinkney McGready

State Registrar of Vital Records



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01276  
REG. NO.

|   |  |  |  |  |   |   |   |  |  |
|---|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>AMELIA F. REBBEL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 15, 1979</b>         |  |   | 2b. HOUR<br>M<br><b>M</b>   |   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 20, 1911</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                               |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5711 Belair Road</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3716 Erdman Avenue 21213</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H. Cole</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie A. McGan</b>  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br><b>5711 Belair Road</b>   |   | ADDRESS<br><b>Florence Cole(sister) 21206</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>(c) <b>Ventricular arrhythmia</b> |  |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12/23/78</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>9/9</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/23, 1978</b> to <b>1/11, 1979</b> , that (I) (we) lost<br>saw the deceased <b>above</b> , (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>James D. Gallant M.D.</b>  |  |  |  |  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>1/16/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. James D. Gallant, M.D.</b>  |  |  |  |  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/19/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Schuminek Funeral Home, Inc.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1a-0151e



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR FILM # G532 6-14-79   |  |                      |  |   |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                       |  |   |  |  |  |         |  |  |  | 79-01277                |  |
|---|--|----------------------|--|---|--|--|--|--|--|--|--|---|--|--|--|---------|--|--|--|-------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE M. REDD</b>  |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>7</b> YEAR <b>1979</b> |  |   |  |  |  |         |  |  |  | 2b. HOUR <b>3:28</b> AM |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH MONTH <b>4</b> DAY <b>18</b> YEAR <b>1968</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS  |  | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>   |  | 7c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>7</b> YEAR <b>1979</b> |  |  |  | 3.28 AM |  |  |  |                         |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD         |  |  |  |         |  |  |  |                         |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2526 W. Lafayette Ave.</b> |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Handler-U.S. Post Off.</b>         |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |         |  |  |  |                         |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b></b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2526 W. Lafayette Ave.</b>  |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b></b> LAST <b>Redd</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Betty</b> MIDDLE <b>C.</b> LAST <b>Carter</b>              |  |  |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>220-09-6681</b>   |  |  |  | 17. INFORMANT ADDRESS <b>Mrs. Susie I. Redd- Same</b>  |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>Arteriosclerotic cardiovascular</b><br>IMMEDIATE CAUSE (a) <b>Smoke inhalation</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>(c) <b></b>  |  |                      |  |   |  |  |  |  |  |  |  |   |  | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |         |  |  |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Severe fatty change of liver &amp; acute alcohol intoxication.</b>  |  |                      |  |   |  |  |  |  |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |         |  |  |  |                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR <b>3:28</b> AM. MONTH <b>1</b> DAY <b>7</b> YEAR <b>1979</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>smoking in bed which caught on fire</b>                                 |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>   |  |  |  | 21f. LOCATION STREET <b>2526 W. Lafayette Ave.</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>                                    |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER   |  |  |  |  |  |  |  | DATE SIGNED <b>1/7/79</b>   |  |  |  |         |  |  |  |                         |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |  |  |   |  |  |  |         |  |  |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>1-12-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat. Cem.</b>                                |  |  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE <b></b>                              |  |   |  |  |  |         |  |  |  |                         |  |
| 24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>  |  |                      |  | ADDRESS <b>3035 W. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1979</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Herbert E. Nutter</b>                   |  |  |  |         |  |  |  |                         |  |

55-01511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 79-01278<br>REG. NO.  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>IRA Raymond REDMAN  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>01/11/79  |  |  |  | 2b. HOUR<br>10:30 P.M.   |
| 3. SEX<br>male   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 10 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   |  | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2910 Woodland Avenue  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRANK Redman  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nettie Gaiter   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)<br>WW II  |  |   |  | 16b. SOCIAL SECURITY NO.<br>235-32-7001   |  | 17. INFORMANT ADDRESS<br>Bessie Taylor 3514 Fairview Avenue                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Respiratory Failure.<br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>(b). CA OF the Lung c metastasis.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c).<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>12/26/78                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 01/11/1979, to 01/11/1979, that (we) lost saw the deceased alive on 01/11/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br>K-S. Chahal  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>01/11/79.  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. S. CHAHAL.   |  |   |  | 22e. ADDRESS<br>SINAI HOSPITAL.<br>BALTIMORE, MD.   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/15/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Maple Hill Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Petersburg, W. Virginia                |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 East North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>R. Kelly   |  |  |

19-01518



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01279

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kathleen</b> <b>Levola</b> <b>REDMOND</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 5 79</b>  |  | 2b. HOUR<br><b>9:30 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 05 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SBGH</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House wife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>217 POPLAR AVE</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NELSON</b> <b>REIGHTLER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>WEND</b> <b>Allbright</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>XXXXXXXX 215/09/8666</b>                                   |  | 17. INFORMANT<br>ADDRESS <b>Same as 13</b><br><b>B Mr. Carl H. Redmond (husband)</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Ca of Colon.</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Cardiac Arrhythmia - Leukopenia</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/31/78</b> , 19 <b>78</b> , to <b>1/5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>B. S. HARRA 22</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. S. HARRA 22</b>   |  |  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 9, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie AA MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>D. Hatter</b> ADDRESS <b>Singleton Funeral Home Glen Burnie, MD</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Kelly</b>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | 79-01280<br>REG. NO.   |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |  |  |  |  |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>VAN LEAR A. Redmond</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-24-1979</b>                                |  | 2b. HOUR<br><b>8:15</b> M   |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-20-1904</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Postal</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Post, Office</b>               |  |  |  |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |   |  | 13e. STREET ADDRESS<br><b>2437 McCulloh Street</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Redmond</b>   |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Lewis</b> |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 38 3556</b>  |  | 17 INFORMANT ADDRESS<br><b>Voial H. Redmond 2437 McCulloh St.</b>  |  |  |  |   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>185-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of prostate with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-13</b> , 19 <b>78</b> , to <b>1-24</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Hyung Chun Kim M.D.</b>   |  |   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1-24-79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HYUNG CHUN KIM</b>   |  |   |  |  |  | 22e. ADDRESS<br><b>Provident Hospital<br/>2600 Liberty Heights Ave. Baltimore</b>      |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>1-29-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Isaiah L. Brown &amp; Son PA 1913 W. Balto. St.</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1979</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Kelly</b>                          |  |  |  |

MEDICAL CERTIFICATION

BP

08510-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A13 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01281

1- FOR  
STATE  
REGISTRAR

|  |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
|--|---------|------------------|--|---|------------------|---|--|---|--------------------------|--------------------------------------|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | FIRST MIDDLE LAST  |   |                  | 2a. DATE KNOWN OF DEATH                                       |  |   |                          | 2b. HOUR                             |  |   |  |  |  |  |  |
| Michael  |         |                  | W. Redolf Redolf   |   |                  | X MONTH DAY YEAR<br>1 9 19 79                                 |  |   |                          | M<br>6:06P                           |  |   |  |  |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                                      |  |   |                          | 2d. HOUR                             |  |   |  |  |  |  |  |
| Male   | White   | July 14, 1966    | 12 YRS.  | MONTHS DAYS   | HOURS MIN        | 1 9 19 79   |  |   |                          | M                                    |  |   |  |  |  |  |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                             |   |                  | 8. MARRIED  |  |   |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |  |  |  |  |
| Maryland   |         |                  | U.S.A.   |   |                  | WIDOWED NEVER MARRIED DIVORCED                                |  |   |                          | Baltimore City, MD.                  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |                          | 12b. KIND OF BUSINESS OR INDUSTRY    |  |   |  |  |  |  |  |
| Baltimore City   |         |                  | St. Agnes Hospital                                       |   |                  | Student   |  |   |                          |                                      |  |   |  |  |  |  |  |
| 13a. STATE   |         |                  | 13b. COUNTY  |   |                  | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS? |                                      |  | 13e. STREET ADDRESS   |  |  |  |  |  |
| Maryland   |         |                  | Lansdowne  |   |                  | YES X NO  |  |   | 3011 Freeway, Balto. Md. |                                      |  |   |  |  |  |  |  |
| 14. FATHER'S NAME  |         |                  |  |   |                  | 15. MOTHER'S MAIDEN NAME                                      |  |   |                          |                                      |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Russell ----- Redolf  |         |                  |  |   |                  | FIRST MIDDLE LAST<br>Betty ----- Phillips                     |  |   |                          |                                      |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |                  |  |   |                  | 16b. SOCIAL SECURITY NO.                                      |  |   |                          |                                      |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| (YES, NO, OR UNKNOWN)<br>No  |         |                  |  |   |                  | (IF YES, GIVE WAR OR DATES)<br>None                           |  |   |                          |                                      |  | Ma. Russell Redolf, Same as above                                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                  |  |   |                  |   |  |   |                          |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Drowning</u>  |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.   |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| (b) _____  |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| (c) _____  |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |   |  |   |                          |                                      |  | 20. AUTOPSY?  |  |  |  |  |  |
|  |         |                  |  |   |                  |   |  |   |                          |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS  |         |                  |  | 21b. TIME OF INJURY   |                  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                          |                                      |  |   |  |  |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  |  | HOUR MONTH DAY YEAR<br>4:01 P.M. 1 9 19 79                  |                  |   |  | fell through ice while ice skating  |                          |                                      |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |         |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |   |  | 21f. LOCATION   |                          |                                      |  |   |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         |                  |  | lake  |                  |   |  | Hillcrest Park  |                          |                                      |  | Balto. Md.  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |  |   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE   |         |                  |  | TITLE (SPECIFY)   |                  |   |  | DATE SIGNED   |                          |                                      |  |   |  |  |  |  |  |
| Thomas D. Smith  |         |                  |  | Deputy Chief  |                  |   |  | 1/10/79   |                          |                                      |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  |  | ADDRESS   |                  |   |  |   |                          |                                      |  |   |  |  |  |  |  |
| Thomas D. Smith, M.D.  |         |                  |  | 111 Penn St.  |                  |   |  | Balto., Md.   |                          |                                      |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  |  | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY                            |  |   |                          | 23d. LOCATION                        |  |   |  |  |  |  |  |
| Burial   |         |                  |  | Jan. 13, 1979   |                  | Glen Haven Mem. Park  |  |   |                          | Glen Burnie, A.A. Co. Maryland       |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |         |                  |  | 25a. DATE REC'D. BY REGISTRAR                               |                  |   |  | 25b. REGISTRAR'S SIGNATURE  |                          |                                      |  |   |  |  |  |  |  |
| McGully Funeral Home, 130 E. Fort Ave. Balto. Md.  |         |                  |  | JAN 12 1979   |                  |   |  | Fitzpatrick   |                          |                                      |  |   |  |  |  |  |  |

18510-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO. 79-01282  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Ronald Joseph Reillo</u>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <u>1</u> DAY <u>6</u> YEAR <u>79</u>  |  | 2b. HOUR<br><u>12:10 P.M.</u>                                  |  |
| 3 SEX<br><u>male</u>   |  | 4. RACE<br><u>Caucasian</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>8</u> DAY <u>22</u> YEAR <u>37</u>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>41</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>   |  | IF UNDER 24 HRS.<br>HOURS <u></u> MIN. <u></u>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Md.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Balto.</u> MD   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Balto.</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>The Good Samaritan Hosp.</u> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Illustrator</u>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Civil Ser.</u>   |  |  |  |
| 13a. STATE<br><u>Md.</u>   |  | 13b. COUNTY<br><u>Catherville</u>  |  | 13c. CITY OR TOWN<br><u></u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>125 Westbury Rd.</u>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>Gregory</u> MIDDLE <u></u> LAST <u>Reillo</u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Helen</u> MIDDLE <u></u> LAST <u>Wentz</u>  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>213-34-0898</u>   |  | 17. INFORMANT<br>ADDRESS<br><u>Mrs. June B. Reillo, 125 Westbury Rd.</u>   |  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Intra abdominal Bleed</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>metastatic Fibrous histiocytoma</u>   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1719</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u></u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u></u>  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>78</u> to <u>Jan 6</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>Jan 5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Davis M. Hahn</u>   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |   |  | 22c. DATE SIGNED<br><u>1/6/79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Davis M. Hahn</u>  |  | 22e. ADDRESS<br><u>Good Samaritan Hosp.</u>  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>1/9/79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Clynmalira U.M. Ch.</u>   |  | 23d. LOCATION<br>CITY OR TOWN <u>Baltimore</u> COUNTY <u>County</u> STATE <u>Md.</u>            |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>M. D. Lawson</u>  |  | ADDRESS<br><u>10 W. Padonia Rd.</u>  |  | DATE RECEIVED BY REGISTRAR<br><u>1/10/79</u>   |  | REGISTRAR'S SIGNATURE<br><u></u>  |  |  |  |  |  |

58-01585

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum detailing an investigation or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01283

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ellen V. Reilly</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01-29-79</b> |   |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 1, 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1002 Jack Place</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Kitchen Helper</b>       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles William Metcalfe</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta B. Richardson</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. John M. Reilly Hampstead, Maryland 21074<br/>502 Houskerville Road</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the sigmoid colon</b><br>1533<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DOE TO, OR AS A CONSEQUENCE OF (b) _____<br>DOE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>August 1978</b> to <b>01-29</b> 19 <b>79</b> , that (I) <del>lost</del> saw the deceased alive in <b>December</b> 19 <b>78</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> <input checked="" type="checkbox"/> (I) <del>did not</del> view the body after death. |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Anne P. Denham MD</b>   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>01-29-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anne P. Denham, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>3001 S. Hanover St. Baltimore 21230</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-1-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McReilly Funeral Home of Broadslyn<br/>237 East Patapsco Avenue Baltimore, Md. 21225</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McReilly</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 79-01284<br>REG. NO.   |  |  |                              |   |  |
|--|--|--|--|---|--|--|--|--|------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Richard W Reilly</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/16/79</b>   |  |  | 2b. HOUR<br><b>8:35 P.M.</b> |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12/28/11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.   |                              | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                               |  |  |                              |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CITY HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                              |   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>ESSEX</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>RIVERVIEW M.H.</b>   |                              |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN J. REILLY</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNA HAFEEY</b>                             |  |  |                              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT ADDRESS<br><b>EDWARD REILLY 129 RIVERTOWN RD</b>                               |  |  |                              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DO TO, OR AS A CONSEQUENCE OF (b) <b>acute inferior wall myocardial infarction</b><br>DO TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b> |  |  |  |   |  |  |  |  |                              |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |  |                              |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |                              |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |                              |   |  |
| 22b. SIGNATURE<br><b>Susan Denman M.D.</b>   |  |  |  |   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                              | 22c. DATE SIGNED<br><b>1/16/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Susan Denman</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Balt City Hosp Balt Md 21224</b>  |  |  |                              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>1/19/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |                              |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J. S. CONNELLY</b>   |  |  |  |   |  | ADDRESS<br><b>300 MACE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |

48510-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01285<br>REG. NO.  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>BERNHARDT REINCKE</b>   |  |  |  | 1 4 79 9:40 AM  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 21 26  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>52 YRS. MONTHS DAYS HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS MEDICAL CENTER BALTO.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>salesman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>retail</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13e. STREET ADDRESS<br><b>1020 W. 38th Street</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>paul J Reincke</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth M. Yeckel</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-7897</b>   |  | 17. INFORMANT ADDRESS<br><b>Martene Wade 1727 Covington St.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 carcinoma of lung, metastatic to liver + head</b><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>alcoholic liver disease and ascites</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>OCTOBER 31, 19 78</b> , to <b>JANUARY 4, 19 79</b> , that (X) (we) lost saw the deceased alive on <b>JANUARY 4, 19 78</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Stu Sippen MD</b> DEGREE   |  |  |  | 22c. DATE SIGNED<br><b>JANUARY 4, 79</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ZIPPER MD</b>   |  |
| 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTO. MD. 21218</b>  |  |  |  | 22f. DATE REC'D. BY REGISTRAR 22g. REGISTRAR'S SIGNATURE<br><b>JAN 10 1979</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/6/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Pk. Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Co., Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J. Stansbury Jr.</b> ADDRESS<br><b>6411 Windsor Mill Rd.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 10 1979</b>  |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   | REG. NO. 79-01286  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RHODA REINHART</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 13 79</b>   |  | 2b. HOUR <b>8:00A</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 28, 1909</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OFFICE WORKER</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FURN. CO.</b>                         |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN MIRVIS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HENRIETTA PARIS</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-14-1838</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Charlotte Lipsicas 6814 Fairlawn Ave (21215)</b>    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>POSSIBLE AORTIC ANEURYSM</b><br><b>4416</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b><br><b>YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <b>John Lavin</b> (this hospital) attended the deceased from <b>JAN 9</b> , 19 <b>79</b> , to <b>JAN 13</b> , 19 <b>79</b> , that <b>he</b> (we) last saw the deceased alive on <b>JAN 13</b> , 19 <b>79</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)                      |  |   |   |  |   |
| 22b. SIGNATURE<br><b>John Lavin</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1-13-79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAVIN</b>  |  | 22e. ADDRESS<br><b>MERCY HOSPITAL / BALTO., MD.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/15/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                        |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOB LEVINSON &amp; BROS 21215</b>  |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |   |  |   |



28-01586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 79-01287   |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUISE W. RESH</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 19 1979</b>  |  | 2b. HOUR<br><b>8:00P</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 17, 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 years</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesperson</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Jewelry</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Arbutus</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Lemmon</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgietta Leishear</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-1708</b>   |  |
| 17. INFORMANT<br><b>Mrs. Grace W. Hastings</b>  |  | ADDRESS<br><b>21207</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Bronchiogenic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>11/24</b> , 19 <b>78</b> , to <b>1/19</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>1/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>G. C. Zichin M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.K. MALHOTRA</b>   |  |   |  | 22e. ADDRESS<br><b>ST AGNES HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/22/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  | ADDRESS<br><b>Balto., Md. 21229</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

BP \_\_\_\_\_

13-01581

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01288

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| EMMA   |  | Reynolds   |  | 1-1-79   |  | 8 P.M.  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female   |  | white  |  | 7 18 05  |  | 73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Md   |  | U.S.   |  |  |  | Baltic City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltic City  |  | Valley View Nursing Home   |  | RETIRED  |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Md   |  |  |  | Baltic   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS  |  |   |  |
| Wm H. O'Brien  |  | Margaret Woller  |  | 1533 Upham Rd  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |
| NO   |  | 216-09-9905  |  | Blusby LPN   |  | Valley View Nursing Home  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 402-   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | Coronary Artery  |  | Sudden  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  | Hypertension   |  | 5+  |  |
|  |  | (c)  |  | Cerebral Embolism  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from  |  | 12/30/78   |  | 1/2/79   |  | that (I) (we) lost  |  |
| saw the deceased alive on  |  | above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |
| Charles F. O'Brien   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 1/2/79   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |
|  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |  | 1/2/79   |  | Parkwood   |  | Baltic Co. COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Paul O'Brien   |  | 6067 Hwy Rd  |  | JAN 8 1979   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

72-01588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01289  
REG. NO.

|   |  |   |  |   |   |   |  |                                    |  |
|---|--|---|--|---|---|---|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLYDE SAMUEL RICE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 19, 79</b> |   |   | 2b. HOUR<br><b>6:20 PM</b>  |  |                                    |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-16-1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>PARKVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8427-A OLD HARFORD RD</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RAILROAD CLERK</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>   |                                    |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |                                    |  |
| 13e. STREET ADDRESS<br><b>8427-A OLD HARFORD RD.</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LUTHER RICE</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAGGIE FITCH</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |                                    |  |
| 16b. SOCIAL SECURITY NO.<br><b>705-07-8628</b>  |  | 17. INFORMANT<br>ADDRESS <b>8427-A OLD HARFORD RD.</b><br><b>MARGRET EDWARDS - SAME AS ABOVE</b>  |  |   |   |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b>  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CORONARY ARTERY DISEASE; DIABETES MELLITUS</b>  |  |   |  |   |   |   |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>AUGUST 19 74</b> , to <b>PRESENT</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>JAN. 19</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.  |  |   |  |   |   |   |  | 22c. DATE SIGNED<br><b>1/19/79</b> |  |
| 22b. SIGNATURE<br><b>Ronald Gillilan MD.</b>  |  | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |   |  |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RONALD GILLILAN</b>   |  | 22e. ADDRESS<br><b>USPHS HOSPITAL<br/>BALTIMORE, Md. 21211</b>  |  |   |   |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 23, 79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Md. Frederick Co. Md.</b>                          |  |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>LORING BYERS FUNERAL DIRECTORS P.A.</b><br><b>8728 Liberty rd. Randallstown Md. 21133</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |                                    |  |

BP \_\_\_\_\_

12-01582

31

WINTER 1961

COLUMBIA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMM - 16 60M 1/75  
(VR A 15 (4))

| FOR<br>STATE<br>REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | 79-01290<br>REG. NO.   |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James A. Rice  |  |   | 2a. DATE OF DEATH<br>JAN. 11 1979   |  | 2b. HOUR<br>6:25 P.M.  |
| 3 SEX<br>male   | 4. RACE<br>black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 2 1898  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Retired                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>BALTO  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>727 Druid Park Lake Dr.                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HADLER Rice   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELISER Rice  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-10-3829A  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Minnie Rice 727 Druid Park Lake Dr.           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC Arrhythmia (Heart Block)<br>4279<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) etiology unknown<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>Winston H. Williams MD  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1/11/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Winston Hugh Williams  |  | 22e. ADDRESS<br>410 Dept. Medicine<br>Provident Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>1-17-79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO CO MD                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  | ADDRESS<br>22224 North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1979                                   | 25b. REGISTRAR'S SIGNATURE<br>Anthony McInerney  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01291  
REG. NO.

|  |  |   |   |  |                            |   |   |  |   |   |  |
|--|--|---|---|--|----------------------------|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Valeria G Rice    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 5 79 |  |                            | 2b. HOUR<br>5:40 P M  |   |  |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 30 16   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                    |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. General |   |  |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Char-Lady |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City   |   |   |  |
| 13a. STATE<br>MD   |  |   | 13b. COUNTY<br>---                            |  | 13c. CITY OR TOWN<br>BALTO |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4705 Pennington Ave. 21226 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>dohm --- Nuber |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA Taube   |                            |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   | 16b. SOCIAL SECURITY NO.<br>215 03 1429 |  |
| 17. INFORMANT<br>Deborah A. Rice                         |  |   |   | 17. ADDRESS<br>4705 Pennington Avenue<br>Balto., Md. 21226   |                            |   |   |  |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

410-

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(c) Acute Myocardial infarction

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 01 04 19 79, to 01 05 19 79, that (I) (we) lost<br>saw the deceased alive on 01 05 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Miguel Fleischman  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>01/05/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Miguel Fleischman   |  |  |  | 22e. ADDRESS<br>South Balto. General Hosp.   |  |   |  |

|  |  |                           |  |  |  |   |  |
|--|--|---------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 9. 1979 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>4200 Pennington Avenue<br>McGully Funeral Home of Curtis Bay Balto., Md. |  |                           |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1979               |  | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.                         |  |



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01292   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>CLAUDINE A RIDGELY  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 16 79  |  | 2b. HOUR<br>2:30 P.M.  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 20, 1904  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Howard Marriottsville   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1930 Mt. View Rd.   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George W. Arrington   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Elizabeth Robinson  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>?  |  | 17. INFORMANT<br>B. Dorsey Ridgely, Sr. Marriottsville Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>severe coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>78</u> , to <u>1/16</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2:30 PM</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Eugenio C. Benitez   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>1/16/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. BENITEZ  |  |  |  | 22e. ADDRESS<br>3300 Wilkens Ave 21229   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br>1-12-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. View Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Howard Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME Harry W. Hought<br>ADDRESS Lykenville, Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

12-01525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | REG. NO. 79-01293  |  |  |   |
|---|--|---|--|---|--|--|--|---|
| 1. DECEASED NAME (FIRST MIDDLE LAST)<br><b>FREDERICK OWEN RIDGELY</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 22 79</b>                                   |  |  |   |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 11 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.  |  | 7b. HOUR<br><b>11:00pm</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD</b>                            |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Press Operator</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Manufacturing</b>   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ELLICOTT CITY</b>   |  | 13c. CITY OR TOWN<br><b>Howard Co.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br><b>GEORGE RIDGELY</b>  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br><b>ELSIE SIMMS</b>  |  | 13e. STREET ADDRESS<br><b>3750 St. Paul Street</b><br><del>3009 S. LOCH RAVEN BLVD</del>  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220124811</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Ruth A. Ridgely Same as # 13</b>   |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>5070 RADIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASPIRATION 2° TO NEUROLOGIC DYSFUNCTION</b><br>SEVERAL WEEKS |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JANUARY 8 1979</b> , to <b>JANUARY 22 1979</b> , that (we) last saw the deceased alive on <b>JANUARY 22 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.        |  |   |  |   |  |  |  |   |
| 22b. SIGNATURE<br><b>Steven H. Resnick</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/23/79</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN H. RESNICK</b>   |  |   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD BALTO, MD 21218</b>   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/25/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City Howard Md.</b>                |  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>MacNabb Funeral Home</b>  |  |   |  | ADDRESS<br><b>Catonsville, Md. 21228</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruth A. Ridgely</b>  |



73-01233

from Operator: 10/10/50  
3750 02. 10/10/50  
XXXXXXXXXX

X

XXXXXX Co.

from: 10/10/50

X

10/10/50 10/10/50  
10/10/50 10/10/50  
10/10/50 10/10/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01294

REG. NO.

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen STEWART Ridgely</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 31 79</b>  |  | 2b. HOUR<br><b>7<sup>25</sup> P M</b>   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 27 77</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>101 6</b>                             |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY-BALTIMORE</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOUSE IN THE PINES - BEL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>        |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Ridgely</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Stewart</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-54-7280</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. D. Stewart Ridgely Same</b>                                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCD</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>Apr 27</b> , 19 <b>71</b> , to <b>31 Jan</b> , 19 <b>79</b> , that (1) <del>most</del> lost saw the deceased alive on <b>31 Jan</b> , 19 <b>79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>most</del> (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-31-79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AM. LEIBSON</b>   |  | 22e. ADDRESS<br><b>3640 FORDS LANE BALTIMORE 21215</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-2-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hampton Mansion</b>                                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Co., Maryland</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1979</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins Sons Co.</b><br>ADDRESS<br><b>4905 York Rd. Balto., Md. 21212</b>   |  |  |  |   |   |

10-01504

John Stewart Ridgely

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John W. Stewart

John W. Stewart

John

Ridgely

John

Stewart

250-54-1250 Mrs. D. Stewart Ridgely

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01295

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THEODORA</b>  |  |  | FIRST MIDDLE LAST <b>RIEDY</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 27 79</b>  |  |  | 2b. HOUR <b>12:30 AM</b>   |  |  |
| 3. SEX <b>FEMALE</b>   |  |  | 4. RACE <b>W.</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 27 16</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware, Pa.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE <b>Md.</b>  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Berger</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hilda Meyer</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO. <b>217-05-3711</b>  |  |  |
| 17. INFORMANT ADDRESS <b>Viola Rein</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |
|  |  |  | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b>  |  |  |  |  |  |  |  |  |
|  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>TERMINAL CARCINOMA OF THE COLON</b>   |  |  |  |  |  |  |  |  |
|  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |
|  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)    |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>1-23</b> , 19 <b>79</b> , to <b>1-27</b> , 19 <b>79</b> , that (I) ( <del>was</del> ) lost saw the deceased alive on <b>1-27</b> , 19 <b>79</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Rosita R. Cruz</b> MD.   |  |  | DEGREE <b>MD.</b>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  | 22c. DATE SIGNED <b>1-27-79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROSITA R. CRUZ</b>  |  |  | 22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPRINKLE) <b>Burial</b>   |  |  | 23b. DATE <b>1/30/79</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Co.</b>   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>M. Kleemann</b>   |  |  | ADDRESS <b>6067 Henkle Rd</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Henry A. Brady</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20510-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- STATE REGISTRAR   |  |                  |  |  |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                                |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |               |  |  |  |  |  | 79-01296  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|------------------|--|--|--|--|--|---|--|--|--|--------------------------------|--|--|--|--|--|--|--|---|--|--|--|---------------|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  |  |  |  |  |  |   |  | FIRST MIDDLE LAST<br>Theresa E. Riggs (Jones)  |  |                                |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>KNOWN ESTIMATED<br>1 31 19 79  |  |  |  |               |  |  |  |  |  | 2b. HOUR<br>M<br>1:15A                                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-5-1960 |  |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>18 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>1 31 19 79 |  |  |  |  |  |   |  |  |  | 2d. HOUR<br>M |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |                  |  |  |  |  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |                                |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |               |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  |                  |  |  |  |  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home & Hospital |  |                                |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TYPIST   |  |  |  |               |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OFFICE                 |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>MD.  |  |                  |  |  |  |  |  |   |  | 13b. COUNTY<br>BALTO.  |  |                                |  |  |  |  |  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |               |  |  |  |  |  | 13d. STREET ADDRESS<br>3241 E. BALTIMORE ST.                |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>NORMAN C. JONES  |  |                  |  |  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GERALDINE MOORE   |  |                                |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |  |  |               |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-74-2903                     |  |  |  |  |  |  |  |  |  | 16c. INFORMANT ADDRESS<br>Mrs. Anna E. Jones - 151 N. Milton Ave. |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9229 IMMEDIATE CAUSE (a) Gunshot wound of abdomen & chest<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |                  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                |  |  |  |  |  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                         |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  |  |  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>12:27 P.M. 1/31/1979   |  |                  |  |  |  |  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>12:27 P.M. 1/31/1979  |  |                                |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>shot accidentally  |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |  |  |  |  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  |                                |  |  |  |  |  |  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>3241 E. Baltimore St. Baltimore Maryland  |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                  |  |  |  |  |  |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |                                |  |  |  |  |  |  |  | 22b. TITLE (SPECIFY)<br>Deputy Chief MEDICAL EXAMINER   |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |  |                  |  |  |  |  |  |   |  | DATE SIGNED<br>1/31/79   |  |                                |  |  |  |  |  |  |  | EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |                  |  |  |  |  |  |   |  | 23b. DATE<br>2-3-79  |  |                                |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD  |  |                  |  |  |  |  |  |   |  | 24a. DATE REC'D. BY REGISTRAR<br>FEB 5 1979  |  |                                |  |  |  |  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br>R. J. McCready  |  |  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 25. FUNERAL DIRECTOR<br>NAME<br>Horton Miller  |  |                  |  |  |  |  |  |   |  | ADDRESS<br>2334 Jefferson St.  |  |                                |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1979   |  |  |  |               |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. McCready                |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

10-01388

*Handwritten signature*



15  
FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH Nelson Rigney</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-20-79</b>   |  | 2b. HOUR<br><b>3:30 A.M.</b>                       |  |
| 3 SEX<br><b>M</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-1-16</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>62 YRS.</b>                     |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt. City</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Chauffeur</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>M.T.A.</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Md.</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3308 Rosekemp Ave.</b>                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph B. Rigney</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan Imhoff</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-3332</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Doris E. Rigney, 3308 Rosekemp Ave.</b>               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OVERWHELMING SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA OF ESOPHAGUS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>12-13-78</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA ESOPHAGUS</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>78</b> , to <b>1/20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Guarido A. Garquilo</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>1-20-79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERARDO A. GARQUILO</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-23-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McCreedy</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-01581

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01298

REG. NO.

|  |  |   |   |  |   |  |   |   |   |  |
|--|--|---|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LULA RINGOLD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 25 1979</b>            |  |   | 2b. HOUR<br>MIN. SEC.<br><b>4:15 P.M.</b>  |   |   |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |   |   |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Medical Center</b> |   |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 15. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>MD.</b>  |  |   | 16b. COUNTY<br><b>BALTO.</b>  |  | 16c. CITY OR TOWN<br><b>BALTO.</b>                          |  | 16d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 16e. STREET ADDRESS<br><b>York Road</b> |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles RINGOLD</b>   |  |   | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Johnson</b> |  |   |  |   |   |   |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 20. SOCIAL SECURITY NO.<br><b>NONE</b>                                |  |   | 21. INFORMANT<br>ADDRESS<br><b>Louis Frazier Reister TOWN, MD</b>  |   |   |   |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>436-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |   |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Decubitus Ulcers.</b>  |  |   |   |  |   |  |   |   |   |  |
| 23. DATE OF OPERATION<br><b>1-25-79</b>  |  |   | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 25. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |  |
| 30. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 32. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 33. I certify that (I) (this hospital) attended the deceased from <b>10-6</b> , 19 <b>78</b> , to <b>1-25</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1-25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |  |   |   |   |  |
| 34. SIGNATURE<br><b>Marsha Brown, MD</b>   |  |   |   |  |   | 35. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 36. DATE SIGNED<br><b>1/27/79</b>   |   |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARSHA BROWN MD</b>   |  |   |   |  |   | 38. ADDRESS<br><b>611 E. Charles Street</b>  |   |   |   |  |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 40. DATE<br><b>1/29/78</b>  |  | 41. NAME OF CEMETERY OR CREMATORY<br><b>STEPHENSON AVE.</b> |  | 42. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SPARKS BALTO. MD.</b>                           |   |   |  |
| 43. FUNERAL DIRECTOR<br>NAME<br><b>M.B. Chatman</b>  |  |   |   |  |   | 44. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1979</b>   |   | 45. REGISTRAR'S SIGNATURE<br><b>Fitzroy McCreedy</b>  |   |  |

13-01530

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |  |                  |  |  |   |  | 79-01299  |  |
|--|-------------------------|--|--|--|------------------|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Romeo Roach</b>  |                         |  |  |  |                  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>1 28 79</b>                         |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 52</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>26</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 28 79</b>   |  | 2b. HOUR<br><b>6:07</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>at home/ 3 S. Payson Street</b> |  |  |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Labora</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>                 |  |   |  |
| 13a. STATE<br><b>Md</b>  |                         | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  | 13e. STREET ADDRESS<br><b>3 S. Payson Street</b>   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Roach</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie Lawson</b>  |                  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>218 56 2318/</b>  |  | 17. INFORMANT ADDRESS<br><b>Mollie Roach 3 S. Payson Street</b>  |                  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute intoxication by combination of codeine and ethanol</b><br>9800<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |  |                  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |  |  |  |                  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1/28/79</b> P.M.   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>ingested codeine and ethanol</b> |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>unk.</b>   |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Unk.</b>   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |                         |  |  |  |                  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan M.D.</b>   |                         |  |  | TITLE (SPECIFY)<br><b>Assistant</b>  |                  |  |  | MEDICAL EXAMINER<br>DATE SIGNED <b>1/28/79</b>                          |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>VIRGINIA L. DOLAN, M.D.</b>   |                         |  |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |                  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1-31-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>   |                  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Isaiah L. Brown &amp; Son PA 1913 W Balto. St.</b>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1979</b>  |                  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia M. Hardy</b>   |  |   |  |   |  |

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Items #21a-21f&amp;22a Film G529

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01300  
REG. NO.FOR 3/6/79 rc  
1- STATE REGISTRAR

|  |  |   |   |  |                                       |  |   |  |  |  |
|--|--|---|---|--|---------------------------------------|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Grace C. ROBERTS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 31 1979</b>   |  |                                       | 2b. HOUR<br><b>10:00P M</b>  |   |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 25, 1888</b>  |                                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |   | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>         |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>California</b>   |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   |  |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Clerk</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b> |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>21201</b>                                     |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                    |  |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-6110</b> |  |
| 17 INFORMANT<br><b>Dale R. Schmidt</b>   |  |   | ADDRESS<br><b>3 East Luray Avenue<br/>Alexandria, Va. 22301</b> |  |                                       | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable Pulmonary Embolism</b><br>8842<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Fracture Left Hip</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Congestive Heart Failure, Aortic Aneurysm</b> |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>nk. P.M. 1 19 79</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Fell out of chair</b>   |                                       |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>501 W. Franklin St. Balto., Md.</b>  |                                       | 22a. I certify that (this hospital) attended the deceased from <b>January 21, 1979</b> to <b>January 31, 1979</b> , that (we) lost saw the deceased alive on <b>January 31, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |   |  |  |  |
| 22b. SIGNATURE<br><b>Gary P. Posner</b>  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |                                       | 22c. DATE SIGNED<br><b>2-1-79</b>  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary P. Posner, M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |  |                                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Feb. 2, '79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1979</b>       |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>   |  | ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Petry/Calvady</b>   |                                       |  |   |  |  |  |



10-01300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 79-01301<br>REG. NO.   |                                   |
|--|--|---|--|--|-----------------------------------|
| I. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VIRGINIA M. ROBERTS</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 11 79</b>   |  | 2b. HOUR<br><b>2:45</b> M  |                                   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 12 18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, MD.</b>                        |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. SEATON Med. CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HWI</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>E. Creed Miller</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa E. Hovatter</b>  |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-18-0445</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. H. Glenn Roberts, Baltimore, Md.</b>                 |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br><b>5990</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sacral decubitus, U.T.F.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>3 months</b> |  |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Recurrent Meningioma (sarcomatous degeneration)</b>  |  |   |  |  |                                   |
| 19a. DATE OF OPERATION<br><b>3/78</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>meningioma</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>June 1, 1978</b> , to <b>January 11, 1979</b> , that (1) (we) last saw the deceased alive on <b>January 11, 1979</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.          |  |   |  |  |                                   |
| 22b. SIGNATURE<br><b>E. Weisbrod</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/11/79</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-15-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Mem. Park</b>                  |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Howard Md.</b>  |  |   |  |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home, Hampstead, Md. 21074</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Hickey McBrady</b>                                  |                                   |

10010-01

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BRIEF

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01302

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                                  |  |   |   |  |
|---|--|--|---|---|----------------------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Estelle Robertson</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 21 79</b> |   |                                  | 2b. HOUR<br><b>9:05 AM</b>   |   |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 12</b>  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of MD. Hospital</b> |   |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>                       |   | 13c. CITY OR TOWN<br><b>City</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luther Brown</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa Alfred</b>   |                                  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>224-12-4680</b>  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Henry Robertson 2603 Liberty Hgt. Ave.</b>  |                                  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>403-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension, Diabetes Mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b><br><b>years</b> |  |  |   |   |                                  |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                                  | 20a. AUTOPSY?<br>Pending<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> , 19 <b>79</b> , to <b>1/21</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>9 AM 1/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (I) (we) (did not) view the body after death.   |  |  |   |   |                                  |  |   |   |  |
| 22b. SIGNATURE<br><b>L. Austin Doyle MD</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                  |  |   | 22c. DATE SIGNED<br><b>1/21/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. Austin Doyle MD</b>  |  |  |   | 22e. ADDRESS<br><b>4008-c Linkwood Road Baltimore</b>   |                                  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/27/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. Md.</b>                  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles A. Rice 1300 Eutaw Pl.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1979</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry H. H. H.</b>                                  |   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

52-01305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR<br>STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 79-01303<br>REG. NO.   |  |   |                             |   |  |
|---|--|---|--|---|--|--|--|---|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN F. ROBERTSON</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>20</b> YEAR <b>79</b>   |  |  |   | 2b. HOUR<br><b>12:05 PM</b> |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |                             | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>S. B. G. H.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                             |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1419 OLIVE ST.</b> |   |                             |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  |  |  |   |                             |   |  |
| 14. FATHER'S NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>HOWARD</b> LAST <b>STONE</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>FLORENCE</b> LAST <b>CHURCH</b>   |  |  |   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-3479</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. William Hartlove, Same as above</b>  |  |  |  |   |                             |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive bilateral bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Chronic passive congestion lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Deforming osteoarthritis</b>                                  |  |   |  |   |  |  |  |   |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Multiple decubitus ulcers</b>   |  |   |  |   |  |  |  |   |                             |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                             |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> , 19 <b>79</b> , to <b>1/20/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |                             |   |  |
| 22b. SIGNATURE<br><b>J. Calderon</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>1/22/79</b>  |                             |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JORGE E. CALDERON</b>   |  |   |  |   | 22e. ADDRESS<br><b>7918 Putney Terrace G.B.</b>  |  |  |   |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Jan. 24, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process Crem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>  |  |   |                             |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McClary Funeral Home, 130 E. Fort Ave, Balto, Md.</b> ADDRESS <b></b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McHenry</b>  |                             |   |  |

BP

10-01303



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01304

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |  |  |  |  |
|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELSIE I. ROBEY</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 16, 1979</b>           |  | 2b. HOUR<br><b>4:00A</b>  |  |  |  |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>W</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11/2/06</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>72</b>  |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HSWE</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>7507 CARROLL AVE</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |   | 13c. CITY OR TOWN<br><b>DUNDALK</b>  |   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>DAVID ENGLE</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MINNIE OSMAND</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT ADDRESS<br><b>DONALD ROBEY CORALHORN RD 2127</b>   |   |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiopulmonary arrest</b><br>TERMINAL CANCER<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I <input checked="" type="checkbox"/> this hospital) attended the deceased from <b>1-3</b> , 19 <b>79</b> , to <b>1-16</b> , 19 <b>79</b> , that (I <input checked="" type="checkbox"/> we) lost saw the deceased alive on <b>1-16</b> , 19 <b>79</b> , and that in (my <input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> we <input type="checkbox"/> did <input type="checkbox"/> did not) view the body after death. |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Don Kuppuswamy MD</b>  |  |   | DEGREE<br><b>MD</b>   |  |   | MEDICAL PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/16/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DEEKI KUPPUSWAMY, M.D.</b>  |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL 100 N. BROADWAY, BALTIMORE, MD</b> |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>1/19/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PAK LAWN</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J.G. CONNELLY</b>   |  |   | ADDRESS<br><b>300 MACE</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

40810-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01305

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |  |
|--|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ellen Robinson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>19</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>12:20 PM</b>  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>26</b> YEAR <b>05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b><br>YRS MONTHS DAYS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospitat</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b> |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. CITY OR TOWN<br><b>Ellicott City</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>619 Pleasant Hill Rd.</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Nathaniel</b> MIDDLE <b>Mills</b> LAST <b>Mills</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Susie</b> MIDDLE <b>Petrie</b> LAST <b>Petrie</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>213 09 6137</b>   |  | 17. INFORMANT<br><b>Daniel C. Robinson</b> ADDRESS <b>Box 223 Rt# 6 Winchester, Va. 22601</b>  |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE LUNGS</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF <b>WITH WIDESPREAD</b><br>(b) <b>METASTASIS, I. LIVER, BONES</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>AND BRAIN</b><br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 8</b> 19 <b>78</b> to <b>Jan 19</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Sept.</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>E. Kasartus, MD</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/19/79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. KASARTUS, MD</b>  |  | 22e. ADDRESS<br><b>1801 FREDERICK RD BALTIMORE, MD 21228</b>   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>1/22/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City, Howard, Maryland</b>                                       |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SLACK Funeral Home, Ellicott City, Maryland 21043</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>   |  |  |   |  |

BP

20810-02

10/10/10

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10/10/10

10/10/10

**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPIGATE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

**NOT TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |                                      |  |                                      |  | 79-01306<br>REG. NO.                            |  |
|---|--|--|--|---|--|--------------------------------------|--|--------------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST                                 |  | 2a. DATE<br>OF DEATH                 |  | 2b. HOUR  |  |
| MARTHA  |  | L.   |  | ROBINSON  |  |                                      |  | 2c. DATE<br>PRONOUNCED<br>DEAD       |  | 2d. HOUR  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS     |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| female  |  | negro  |  | 5 05 73   |  | 73 YRS.                              |  |                                      |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED<br>WIDOWED   |  | 8. NEVER MARRIED<br>DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 9. BALTIMORE CITY OR COUNTY OF DEATH            |  |
| VA.   |  | USA  |  |   |  |                                      |  | Baltimore City                       |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK<br>FOR MOST OF WORKING LIFE)           |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |                                      |  |   |  |
| Baltimore   |  | Maryland General Hospital  |  | Ret.  |  |                                      |  |                                      |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES NO   |  | 13e. STREET ADDRESS                  |  |   |  |
| Md.   |  |  |  | Balto.  |  | YES X NO                             |  |                                      |  |   |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST    |  | MIDDLE                               |  | LAST  |  |
| Walter  |  |  |  | Thornton  |  | Catherine                            |  |                                      |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS                              |  |                                      |  |   |  |
| N/O   |  | 156-30-0709  |  | Mrs. Mary Flood   |  | 1102 N. Druid Hill                   |  |                                      |  | Av  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |                                      |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |                                      |  |                                      |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |                                      |  | 20. AUTOPSY?<br>YES NO X             |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |  |                                      |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK OR NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                      |  |                                      |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner  |  |  |  |   |  |                                      |  |                                      |  |   |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |                                      |  |                                      |  |   |  |
| Virginia L. Dolan   |  | Assistant  |  | 1-19-79   |  |                                      |  |                                      |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | ADDRESS  |  |   |  |                                      |  |                                      |  |   |  |
| Virginia L. Dolan, M.D.   |  | 111 Penn St.   |  |   |  |                                      |  |                                      |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN        |  | COUNTY                               |  | STATE   |  |
| Burial  |  | 1-24-79  |  | Arbutus Mem. Park   |  | Arbutus                              |  |                                      |  | Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE           |  |                                      |  |   |  |
| Samuel T. Redd  |  | 5209 York Rd   |  | JAN 22 1979   |  | L. J. Brady                          |  |                                      |  |   |  |

20010-01

20010-01

Items 5,8 8528 2/9/79 83

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01307

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST WALLACE MIDDLE LAST ROBINSON, SR.  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-22-79  |  | 2b. HOUR<br>1:50 PM  |
| 3 SEX<br>Male  | 4 RACE<br>Black  | 5 DATE OF BIRTH MONTH DAY YEAR<br>9-19-1913  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD   |  |  |
| 10 CITY OR TOWN OF DEATH<br>City   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shenandoah University |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE Maryland   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balt.   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Robinson   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO                        |  |  |
| 16b. SOCIAL SECURITY NO.<br>214-163943   |  | 17. INFORMANT ADDRESS<br>Frances Robinson 1925 Walbrook Ave  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>BILATERAL SUBDURAL HEMATOMAS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CERVICAL 4-5 DISLOCATION</u>   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MIN<br>7 DAYS<br>25 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>DIABETES MELLITUS</u>   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>1/15/79  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>SUBDURAL HEMATOMA BILAT  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>2:30 P.M. 12 29 1978   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>FELL DOWN STAIRS AT HOME   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>HOME  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>1925 Walbrook BALTO BALTO MD   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 29</u> , 19 <u>78</u> , to <u>Jan 22</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Jan 22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br>Theodore M. Braun  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>1-22-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THEODORE M. BRAUN   |  | 22e. ADDRESS<br>22 S Green St Balt Md  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>1/26/79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 East North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |  |

The medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



7010-01307



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01308

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 7b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 1 14 79  |  | 10:55 P.M.  |  |
| Elijah (Rogers) ROGERS   |  |  |  |  |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | Negro  |  | MONTH DAY YEAR   |  | 55 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| South Carolina   |  | U. S. A.   |  |  |  | CITY MD   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALT.  |  | SINAI HOSP.  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| William  |  | Mary   |  | No   |  | 250-28-1248   |  |
| 17. INFORMANT  |  | ADDRESS  |  | 17. INFORMANT  |  | ADDRESS   |  |
| Walter Rodgers   |  | 2521 East Biddle St.   |  | Walter Rodgers   |  | 2521 East Biddle St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |   |  |
| 1552 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |
| (c) Carcinoma of Liver   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |
|  |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29, 1978, to 1/14, 1979, that (I) (we) lost saw the deceased alive on 1/14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |
| Robert A. Wacks  |  | M.D.   |  | 1/14/79  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE OF DEATH BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE  |  |
| Robert A. Wacks  |  | Sinai Hosp of Balt.  |  | JAN 17 1979  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |  | 1/19/79  |  | Westview Mem. Cem.   |  | Catonsville Maryland  |  |
| 24. FUNERAL DIRECTOR   |  | NAME   |  | ADDRESS  |  | 25a. DATE OF DEATH BY REGISTRAR                                     |  |
| Wm. C. March F/H   |  | 1101 East North Ave.   |  |  |  | JAN 17 1979   |  |

72-01308

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01309

REG. NO.

|  |   |  |                                   |   |   |                                  |   |
|--|---|--|-----------------------------------|---|---|----------------------------------|---|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH  |                                   | MONTH   | DAY   | YEAR                             | 2b. HOUR  |
| 1 DECEASED NAME (TYPE OR PRINT)  |   | FIRST  | MIDDLE                            | LAST  |   |                                  |   |
| Thomas   |   | Rodgers  |                                   |   |   | Jan 8 79 158 AM                  |   |
| 3. SEX   | M   | 4 RACE   | B                                 | 5 DATE OF BIRTH   | MONTH DAY YEAR  |                                  | 6 AGE (IN YEARS LAST BIRTHDAY)                                |
|  |   |  |                                   | 03 22 00  | 78 YRS  |                                  | 3 22  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | va  | 7b CITIZEN OF WHAT COUNTRY?  | us                                | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                                  |   |
| BALTO  |   | Bon Secours  |                                   | Baltimore   |   |                                  | MD  |
| 10 CITY OR TOWN OF DEATH   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b KIND OF BUSINESS OR INDUSTRY |   |
| BALTO  | Bon Secours   |  |                                   | Wine mill   |   | Both Steel                       |   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13b COUNTY   | 13c CITY OR TOWN                  | 13d INSIDE CITY LIMITS?   | 13e STREET ADDRESS  |                                  |   |
| m k  |   |  | BALTO                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 1917 W Lafayette St.  |                                  |   |
| 14 FATHER'S NAME   |   | FIRST  | MIDDLE                            | LAST  | 15 MOTHER'S MAIDEN NAME   |                                  |   |
| ?  |   |  |                                   |   | MARY ?  |                                  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |   | 16b SOCIAL SECURITY NO.  |                                   | 17 INFORMANT ADDRESS  |   |                                  |   |
| No   |   | 213 07 6743  |                                   | Cecilia Hall 1917 W. Lafayette St.  |   |                                  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4349   |   |  |                                   |   |   |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |
| DUE TO, OR AS A CONSEQUENCE OF (b) 4349  |   |  |                                   |   |   |                                  | 11 DAYS   |
| DUE TO, OR AS A CONSEQUENCE OF (c) 4349  |   |  |                                   |   |   |                                  | 11 DAYS   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |   |  |                                   |   |   |                                  |   |
| CONGESTIVE HEART FAILURE - ASCVD - HCD.  |   |  |                                   |   |   |                                  |   |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   |   | 20a AUTOPSY?  |                                  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |  |                                   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                                   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |                                  |   |
|  |   | P.M. 19  |                                   |   |   |                                  |   |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |   |                                  |   |
|  |   |  |                                   |   |   |                                  |   |
| 22a I certify that (I) (this hospital) attended the deceased from 12-27 19 78 to 1-08 19 79 that (I) (we) lost saw the deceased alive on 1-07 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |                                   |   |   |                                  |   |
| 22b SIGNATURE  |   | DEGREE   |                                   |   |   | 22c DATE SIGNED                  |   |
| Oscar E. Ferdinandini M.D.   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   |   |   | 1-08-79                          |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e ADDRESS  |                                   |   |   |                                  |   |
| OSCAR E. FERNANDINI  |   | 2025 W. FAYETTE ST. BALTO, MD. 21223   |                                   |   |   |                                  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b DATE   | 23c NAME OF CEMETERY OR CREMATORY |   | 23d LOCATION CITY OR TOWN COUNTY STATE                              |                                  |   |
| Burial   |   | 1/12/79  | Mt. Calvary                       |   | A.A. County, Md.  |                                  |   |
| 24 FUNERAL DIRECTOR NAME   |   | 24b ADDRESS  |                                   | 25a DATE REC'D. BY REGISTRAR  |   | 25b REGISTRAR'S SIGNATURE        |   |
| LOCKS FUNERAL HOME   |   | 1304 N. Central Ave  |                                   | JAN 9 1979  |   | Anthony McCurdy                  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

The following information was obtained from the records of the  
 Bureau of the Census, Washington, D.C., on the date of the  
 investigation, and is being furnished to you for your information.  
 The information was obtained from the records of the Bureau of the  
 Census, Washington, D.C., on the date of the investigation, and is  
 being furnished to you for your information.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01310

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |   |  |
|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CYNTHIA M ROGERS</b>          |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JAN. 19 1979</b>   |   |   | 2b. HOUR<br><b>5:17 A.M.</b>  |  |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 4 55</b>                          |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>23</b> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD. HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FROM LAST OF WORKING LIFE)<br><b>Optometrist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Assistant</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LLOYD HENDERSON</b>     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ISABELL REED</b>          |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-60-3914</b> |   | 17. INFORMANT ADDRESS<br><b>Mrs. Isabell J. Henderson- Same</b>                         |   |   |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>586-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>card failure, 56 transplanted organ, repair</b><br>(c) <b>Renal Failure</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>renal failure</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/18/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18/79</b> , 19 <b>79</b> , to <b>1/19</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Gary C. Proda ms</b>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/19/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary C. Proda ms</b>  |  |  |  | 22e. ADDRESS<br><b>Univ. Hosp</b>  |  |  |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>          |  | 23b. DATE<br><b>1-23-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Herbert E. Nutter 3035 W. North Ave.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dickie McCreedy</b>               |  |

79-01310





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01311  
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELIZABETH A ROMETSCH  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 18, 1979   |  | 2b. HOUR<br>1:40 P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 23, 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5219 Tramore Road  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br>3330 Woodside Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Geckle  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Shipley   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-09-3015   |  |
| 17. INFORMANT<br>ADDRESS<br>Elizabeth I Lerch Same  |  | 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Coronary sclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertensive C-V disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Diabetes Mellitus</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hrs.</u><br><u>10 yrs</u><br><u>25 yrs</u>   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Feb 11, 1974</u> to <u>Jan 18, 1979</u> , that (I) (we) last saw the deceased alive on <u>Jan 18, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Harold V. Harbold MD</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><u>Jan 19, 1979</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold V. Harbold  |  | 22e. ADDRESS<br>4706 Harford Road Baltimore, Maryland   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/22/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby [Signature]</u>  |  |

11010-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 79-01312<br>REG. NO.  |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR  |  |  |  |
| I DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><u>William ROMOSER</u>   |  |  |  | <u>January 5 1979</u>   |  |  |  | <u>8:25A M</u>  |  |  |  |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>Cau</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>2 5 01</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><u>77</u> YRS.                     |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Indiana</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                            |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Maryland General Hospital</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Brewery Worker</u>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Schaefer's</u>  |  |  |  |
| 13a. STATE<br><u>Md.</u>  |  | 13b. COUNTY<br><u>-</u>  |  | 13c. CITY OR TOWN<br><u>Balto.</u>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>827 Hollins St. 21201</u>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>William Rosomer</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Edith Kent</u>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>Yes.</u>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><u>W.W. 11 213-12-6972</u>   |  | 17. INFORMANT ADDRESS<br><u>Mrs. James P. Rosomer 3101 Evergreen Ave.</u>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic Shock</u><br><u>6012</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic Abscess</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>11-17-78</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Sigmoid Adenocarcinoma</u>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that <del>XX</del> (this hospital) attended the deceased from <u>October 24</u> , 19 <u>78</u> , to <u>January 5</u> , 19 <u>79</u> , the <del>XX</del> (we) last saw the deceased alive on <u>January 5</u> , 19 <u>79</u> , and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (we) did <del>not</del> view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><u>1-5-79</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Farouk A. Sultani, M.D.</u>   |  |  |  | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>1-8-79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gardens of Faith Cem.</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Balto. Balto. Md.</u>                          |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><u>John C. Miller Inc.</u>   |  |  |  | ADDRESS<br><u>6415 Belair Rd.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 8 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

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W. H. Miller Inc. 175 Main St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 79-01313<br>REG. NO.                         |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Reuben R. EUGENE ROSENSTEIN   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan 26 1979  |  | 2b. HOUR<br>12:30 PM                         |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 8, 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 72 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Architect   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Baltimore, Md.<br>2412 Pelham Avenue  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Reuben Rosenstein  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Elizabeth Shanbarger   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW I 214-01-8867  |  | 17. INFORMANT Nephew:<br>E. Herbert Fosler  |  | ADDRESS<br>Baltimore, Md.<br>905 Weatherbee Road  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia (pneumococcal) with Sepsis</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction, Cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic disease</u> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 16, 1979, to Jan 26, 1979, that (I) (we) last saw the deceased alive on Jan 24, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Heidi J. Bland M.D.   |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br>Jan 26, 1979   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Veita J. Bland   |  |   |  | 22e. ADDRESS<br>Union Memorial Hospital   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>1-27-1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.   |  |   |  |   |  | ADDRESS<br>Baltimore, Maryland  |  | 25. DATE RECEIVED BY REGISTRAR<br>JAN 29 1979  |  | REGISTRAR'S SIGNATURE                        |  |

72-01313



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01314<br>REG. NO.  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR P.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ABRAHAM ROSENSWEIG</b>  |  |  |  | JAN. 23, 1979   |  |   |  | 2:20 M   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>AUG. 12, 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD                           |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>CHAUFFEUR</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRUCK</b>                      |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXXX |  | 13e. STREET ADDRESS<br><b>3630 YENMAR LA., APT. 2A</b>                 |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ISAAC ROSENSWEIG</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WWII Army 214-14-1122</b>   |  | 17. INFORMANT <b>MRS. BETTY ROSENSWEIG</b>  |  | 3630 YENMAR LA., APT. 2A  |  | #21207   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>hypertensive disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>years</b><br><b>years</b> |  |  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>JAN</b> , 19 <b>78</b> , to <b>JAN</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>January 4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Harry M. Walen</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>1/24/79</b>                                     |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. HARRY WHELAN WALEN, MD</b>   |  |  |  | 22e. ADDRESS<br><b>10807 FALLS RD., LUTHERVILLE, MD</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>JAN. 25, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b>                                     |  | 23d. LOCATION CITY COUNTY MARYLAND                                     |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  | ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1979</b>                     |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1 - STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 79-01315<br>REG. NO.   |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Kathryn A. ROSS</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 20, 1979</b>                                     |  | 2b. HOUR<br><b>935 P M</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 22, 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>65</b>                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |
| 13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>307 Wendover Road</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Anderson</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Vernelson</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-18-3597</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Ralph A. Ross, Jr. Same</b>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Upper gastrointestinal hemorrhage</b><br><b>5789</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Chronic pancreatitis; Cirrhosis; Atherosclerotic vascular disease</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED.   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>May 19 75</b> to <b>Jan 19 79</b> , that (1) (we) last saw the deceased alive on <b>Jan 19 79</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>James M. Sowa</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>22 Jan 1979</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. James M. Sowa, M.D.</b>   |   | 22e. ADDRESS<br><b>714 York Road Balto., Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/24/79</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Petryal Rudy</b>  |

21610-85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01316  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |  |   |   |  |
|--|--|--|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY E. VAN ROSSUM</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 24, 1979</b>         |  |  | 2b HOUR<br>M   |  |   |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>CAUCASIAN</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR 6, 1898</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>80</b>  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b>   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4025 PARKSIDE DRIVE</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANICAL WORK</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMP.</b>  |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD</b>   |  |  | 13b COUNTY<br><b>-</b>  |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>4025 PARKSIDE DR 21206</b> |  |
| 14 FATHER'S NAME<br>FIRST LAST<br><b>GEORGE E. VAN ROSSUM</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA C HECKEL</b>  |  |  |  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>220-09-5569</b>                         |  | 17 INFORMANT<br>ADDRESS<br><b>JOHN VAN ROSSUM, 1401 PHILA. RD. JOHN MD 21085</b> |  |  |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b><br>4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Renal Failure</b>  |  |  |   |  |  |  |  |   |   |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |   |  |  |  |  |   |   |  |
| 22b SIGNATURE<br><i>Anderson M. Renick, Jr.</i>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c DATE SIGNED                                     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDERSON M. RENICK, JR MD</b>   |  |  |   |  |  | 22e ADDRESS<br><b>3100 ST. PAUL 21218</b>  |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  |  | 23b DATE<br><b>26 JAN 79</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CEM.</b>                     |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD</b>                              |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>ULBRICH FUNERAL HOME, BALTO. MD 21206</b>  |  |  |   |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 26 1979</b>   |  | 25b REGISTRAR'S SIGNATURE<br><i>Barney McCreedy</i>   |   |  |

BP \_\_\_\_\_

78-01316

NAME: Daniel G. Rubin

DATE OF DEATH: January 28, 1979

PLACE OF DEATH: Baltimore City

SEE: 79-04018  
February, 1979  
Baltimore City

WHITE 15

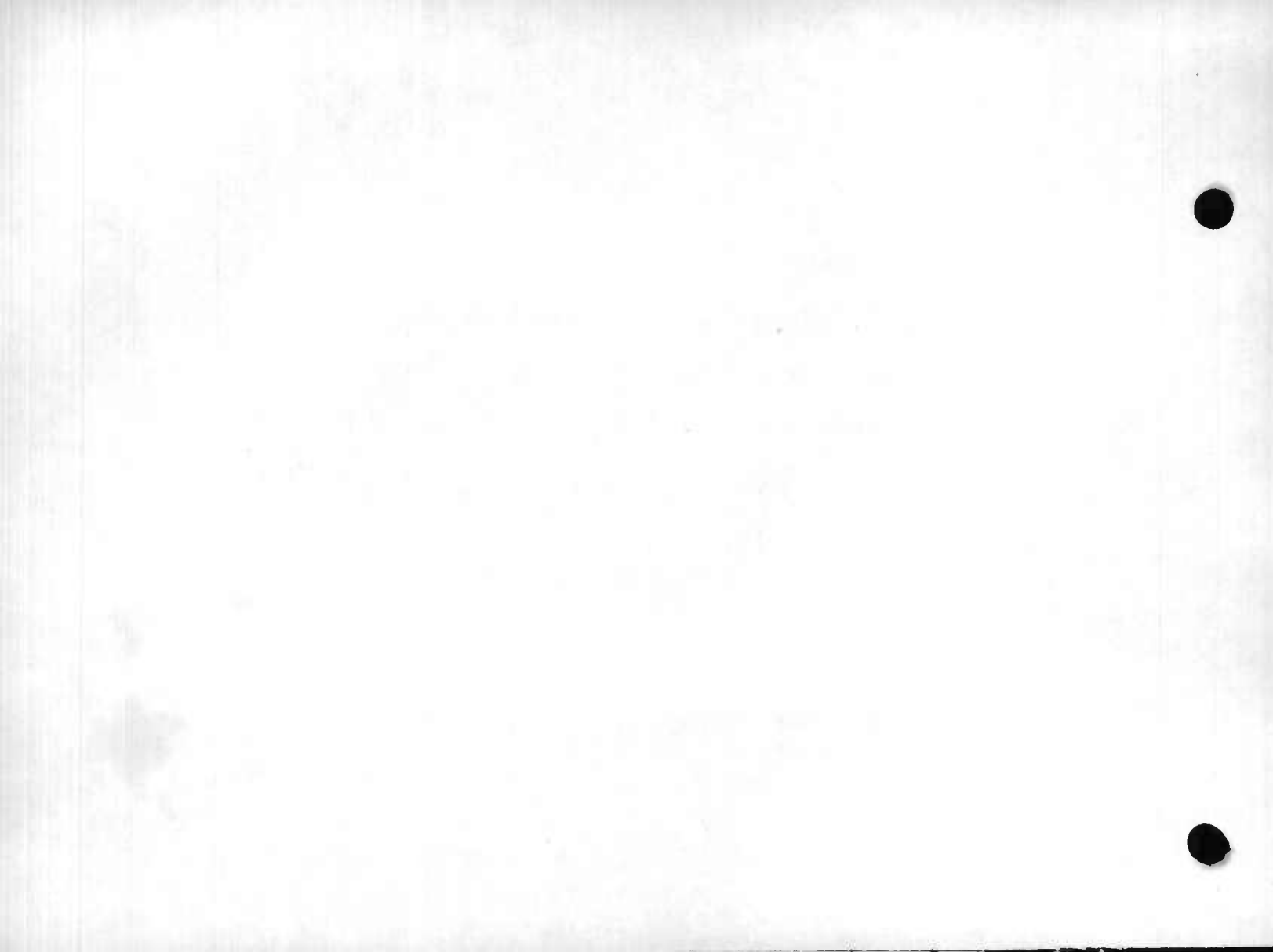


NAME: Elizabeth C. Ruppert

DATE OF DEATH: January 25, 1979

PLACE OF DEATH: Baltimore City

SEE: # 79-04020  
February, 1979  
Baltimore City



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01317  
REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |   |
| James Rush  |  | 1 13 19 79  |   | M  |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR.                                    | 8. IF UNDER 24 HRS.   |
| Male  | Black  | 1 20 13   | 65 YRS.   |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |
| South Carolina  | U. S. A.   | NEVER MARRIED   | Baltimore City, MD.   |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION                                       | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |
| Baltimore City  | 946 N. Washington Street                                 |   |   |  |   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                                  |   |
| Maryland  |  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 946 N. Washington Street                             |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                 |   |   |  |   |
| Melvin Rush   | Rosa Brown   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16b. SOCIAL SECURITY NO.                                 | 17. INFORMANT ADDRESS                                       |   |  |   |
| Yes   | 248-10-2196  | Mae Barnett 1706 N. Wolfe St.                               |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY:   |  |   |   |  |   |
| IMMEDIATE CAUSE (a) Scleroderma   |  |   |   |  |   |
| 7101 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last   |  |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |  |   |
| (b)   |  |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |  |   |
| (c)   |  |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  | 20. AUTOPSY?  |
|   |  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED                             |   |
|   |  | HOUR A.M. MONTH DAY YEAR                                    |   | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION  |   |
|   |  |   |   | CITY OR TOWN COUNTY STATE                            |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |  |   |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |   | DATE SIGNED  |   |
| Thomas D. Smith, M.D.   |  | Deputy Chief  |   | 1/14/79  |   |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |   |  |   |
| Thomas D. Smith, M.D.   |  | 111 Penn St. Balto., Md.                                    |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                          | 23d. LOCATION   | COUNTY   | STATE   |
| Burial  | 1/18/79  | Cedar Hill Cemetery   | Anne Arundel Co., Md.   |  |   |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                               |   | 25b. REGISTRAR'S SIGNATURE                           |   |
| Wm. C. March F/H  |  | JAN 17 1979   |   | [Signature]  |   |
| NAME ADDRESS  |  |   |   |  |   |
| 1101 East North Ave.  |  |   |   |  |   |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM-17  
(VR A15 ME (5))  
30M 7/73

18-01311

2000  
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1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and file in pages 4 and 5. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. <b>79-01318</b>                        |  |                |  |          |  |
|---|--|---|--|---|--|---|--|---|--|---|--|----------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   |  |   |  | 2a. DATE OF DEATH                               |  | MONTH DAY YEAR |  | 2b. HOUR |  |
|   |  | GANNON JOSEPH RUSS  |  |   |  |   |  |   |  | JANUARY 30, 1979                                |  | 5:15A          |  |          |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                                |  |                |  |          |  |
| male  |  | caucasian   |  | Jan. 9, 1966  |  | 13  |  | MONTHS DAYS   |  | HOURS MIN                                       |  |                |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |   |  |                |  |          |  |
| Maryland  |  | U. S.   |  |   |  | BALTIMORE CITY  |  |   |  |   |  |                |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                |  |          |  |
| Baltimore   |  | THE JOHNS HOPKINS HOSPITAL  |  |   |  |   |  | student   |  |   |  |                |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |                |  |          |  |
| Maryland  |  | Talbot  |  | Cordova   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Rt. #1, Box 274   |  |   |  |                |  |          |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |   |  |                |  |          |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST   |  |   |  |   |  |   |  |                |  |          |  |
| Robert S. Russ  |  |   |  | Regina Gannon   |  |   |  |   |  |   |  |                |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |   |  |                |  |          |  |
| no  |  | 235-98-7557   |  | Robert S. Russ  |  | see item 13   |  |   |  |   |  |                |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                |  |          |  |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>   |  |   |  |   |  |   |  |   |  | 30 MIN  |  |                |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| (b) <u>POSSIBLE BRAIN STEM BLEED</u>  |  |   |  |   |  |   |  |   |  | 12 HRS  |  |                |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| (c) <u>ACUTE NON LYMPHOCYTIC LEUKEMIA - 1st RELAPSE</u>   |  |   |  |   |  |   |  |   |  | 2 MOS   |  |                |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |   |  |                |  |          |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |   |  |                |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |                |  |          |  |
|   |  | P.M. 19   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |                |  |          |  |
|   |  |   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>5 December</u> 19 <u>78</u> to <u>30 January</u> 19 <u>79</u> , that (I) (we) last<br>saw the deceased alive on <u>30 January</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |   |  |                |  |          |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED  |  |   |  |                |  |          |  |
| <u>Mary J. Murphy, MD</u>   |  |   |  |   |  |   |  | 1-30-79   |  |   |  |                |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |  |   |  |   |  |                |  |          |  |
| MARY J. MURPHY  |  |   |  | JOHNS HOPKINS HOSPITAL BALTIMORE, MD.   |  |   |  |   |  |   |  |                |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |  |   |  |                |  |          |  |
| Burial  |  | 2-1-1979  |  | Spring Hill   |  |   |  | Easton, Talbot, Md.   |  |   |  |                |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | ADDRESS   |  |   |  | 25a. DATE REGD. BY REGISTRAR                                      |  | 25b. REGISTRAR'S SIGNATURE                      |  |                |  |          |  |
| Newnam Funeral Home   |  |   |  | Easton, Md.   |  |   |  | FEB 1 1979  |  | <u>Mary J. Murphy</u>                           |  |                |  |          |  |

MEDICAL CERTIFICATION

72-01318

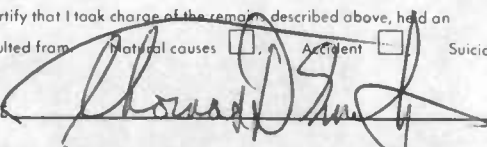
FEB 1 1953

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE FORMS 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

R.G. NO. **78-01319**

|   |   |  |   |   |                                   |
|---|---|--|---|---|-----------------------------------|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH  |   | 2b. HOUR  |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2a. DATE KNOWN OF DEATH  |   | 2b. HOUR  |                                   |
| FIRST MIDDLE LAST   |   | MONTH DAY YEAR   |   | M   |                                   |
| Dennis R. Russell   |   | 1 24 1979  |   | M   |                                   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YR.   | 7. IF UNDER 24 HRS.               |
| Male  | Black   | 1 1 1959   | 20 YRS.   | MONTHS DAYS   | HOURS MIN                         |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 9. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |
| Maryland  | U. S. A.  |  |   | Baltimore City, MD.   |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore City  | Maryland General Hospital   |  |   |   |                                   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                                   |
| Maryland  |   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2130 Division Street  |                                   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |   |                                   |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST   |  | 16b. SOCIAL SECURITY NO.  |   |                                   |
| Alfoster Russell  | Delores Stevenson   |  | 17. INFORMANT ADDRESS   |   |                                   |
|   |   |  | Margaret Watkins 2130 Division St.                                  |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |   |   |                                   |
| PART I DEATH WAS CAUSED BY:   |   |  |   |   |                                   |
| IMMEDIATE CAUSE (a) <u>Stab wound of abdomen</u>  |   |  |   |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |   |   |                                   |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |   |  |   |   |                                   |
| (b) _____   |   |  |   |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |   |   |                                   |
| (c) _____   |   |  |   |   |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |  |   |   |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?  |                                   |
|   |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |                                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)         |                                   |
|   |   | HOUR MONTH DAY YEAR  |   |   |                                   |
|   |   | 10:15M 1 23 1979   |   | stabbed during altercation  |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION   |                                   |
|   |   | store  |   | STREET CITY OR TOWN COUNTY STATE  |                                   |
|   |   |  |   | 2139 Pennsylvania Ave. Balto MD   |                                   |
| 22a. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |   |                                   |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)  |   | DATE SIGNED   |                                   |
|    |   | M.D. Deputy Chief  |   | 1/24/79   |                                   |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | ADDRESS  |   |   |                                   |
| Thomas D. Smith, M.D.   |   | 111 Penn St. Balto., MD.   |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                   |
| Burial  |   | 1/27/1979  |   | Mt. Auburn Cem.   |                                   |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |                                   |
| NAME ADDRESS  |   | JAN 25 1979  |   |  |                                   |
| Wm. C. March F/H 1101 East North Ave.   |   |  |   |   |                                   |

MEDICAL CERTIFICATION



92-01312

*[Faint, illegible signature]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01320

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Molly (aka Mollie or Marcianna) L. Rutkowski   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 13 79   |  | 2b. HOUR<br>4 <sup>55</sup> AM   |
| 3 SEX<br>Female   | 4 RACE<br>White  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Jan. 1, 1904   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                      |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>---   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>577 S. Potomac Street   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>John (nmi) Lukaszewski  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pauline (nmi) Kucinski   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-40-3749  | 17 INFORMANT ADDRESS<br>Gertrude R. Szymanski-1617 Myamby Road #21204                           |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (he (this hospital) attended the deceased from <u>1/4</u> , 19 <u>79</u> , to <u>1/13</u> , 19 <u>79</u> , that (he (we) last saw the deceased alive on <u>1/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>James Oshida</u>   |  | DEGREE<br>MD.  |   | 22c. DATE SIGNED<br>1/13/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>James Oshida</u>  |  | 22e. ADDRESS<br><u>Good Samaritan Hospital.</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/17/79   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cem.                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland   |
| 24. FUNERAL DIRECTOR NAME<br>George A. Weber & Sons Inc.-705 S. Ann St.   |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 16 1979  |  |  |
|   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James Oshida</u>   |  |  |

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

58-01350



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-01321  |  |
|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <i>Leo</i> FIRST <i>B.</i> MIDDLE <i>Rutz</i> LAST <i>jr</i>   |  | 26. DATE OF DEATH MONTH DAY YEAR 1-26-79 11 P.M.                               |  |
| 3. SEX <i>Male</i>  | 4. RACE <i>White</i>   | 5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 17, 1939</i>  | 6. AGE (IN YEARS, LAST BIRTHDAY) <i>39</i> YRS.                | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. |  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4108 Mariban Court 21225</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Military</i>  | 12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. C. Guard</i>         |  |  |
| 13a. STATE <i>Maryland</i>  |  | 13b. COUNTY   | 13c. CITY OR TOWN <i>Baltimore</i>                             | 13d. STREET ADDRESS <i>4108 Mariban Court 21225</i>                            |  |
| 14. FATHER'S NAME FIRST <i>Pete</i> MIDDLE LAST <i>Rutz</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST <i>Ruth</i> MIDDLE <i>O.</i> LAST <i>Tuders</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>  |  | 16b. SOCIAL SECURITY NO. <i>537 34 8044</i>   |  | 17. INFORMANT ADDRESS <i>4108 Mariban Court Baltimore, Md. 21225</i>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Ca ESOPHAGUS</i><br><i>1509</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 months</i> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>July</i> 19 <i>77</i> , to <i>Jan 26</i> 19 <i>79</i> , that (1) (we) last saw the deceased alive on <i>Dec 26</i> 19 <i>77</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did/did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE <i>MB Porelman</i>   |  | DEGREE  |  | 22c. DATE SIGNED <i>1-27-79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MB PORELMAN MD</i>   |  | 22e. ADDRESS <i>245 Baltimore Blvd G.R. Md.</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>Jan. 31, 1979</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Pk.</i>                  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, Maryland</i>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>McGully Funeral Home of Brooklyn Balto., Md.</i>   |  | 25a. DATE REC'D. BY REGISTRAR <i>AN 30 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Kirby McBrady</i>                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01322  
REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MOSES</b>   |  | FIRST MIDDLE LAST <b>RZETELNY</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 18 1979</b>   |  | 2b. HOUR <b>1:00 P.M.</b>   |  |
| 3 SEX <b>MALE</b>  |  | 4 RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 20 1918</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GERIATRIC CENTER &amp; HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FURRIER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>FURS</b>   |  |
| 13a. STATE <b>MARYLAND</b>   |  |   |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>HERSH RZETELNY</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>ROSE FEFFERKRAWTZ</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>213-64-5779</b>   |  | 17. INFORMANT ADDRESS <b>MRS. BRONISLAWA RZETELNY</b><br><b>3601 FORDS LA., APT. 502 #21215</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPERNEPHROMA WITH BONE, LUNG &amp; BRAIN METASTASES</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DIAGNOSED 4-5 MONTHS AGO</b> |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>DEC. 20</b> 19 <b>78</b> , to <b>JAN. 18</b> 19 <b>79</b> , that (we) lost saw the deceased alive on <b>JAN. 18</b> 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did not view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED <b>1/18/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KIL</b>  |  |   |  | 22e. ADDRESS <b>GERIATRIC CENTER &amp; HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>JAN. 21, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>(ARLINGTON) CHIZUK AMUNO</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR'S NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN ROAD, BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

58-01355



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to release.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-01323  |  |
|---|--|--|--|--|--|
| 1. FOR<br>- STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <del>XXXXXX</del> Beverly Anne Saffell <del>XXXXXX</del>   |  | 2a. DATE OF DEATH MONTH DAY YEAR 1/22/79   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR Aug 3 1934   |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md. Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland   |  | 13b. COUNTY Balto.   |  | 13c. CITY OR TOWN Sparks   |  |
| 14. FATHER'S NAME<br>Louis R. Hilgartner  |  | 15. MOTHER'S MAIDEN NAME<br>Anna Fendlay   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 133 Ensor Mill Road |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) no   |  | 16b. SOCIAL SECURITY NO. 215 30 2692   |  | 17. INFORMANT ADDRESS Robert L. Saffell  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) BOWEL SURGERY<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) BOWEL OBSTRUCTION 2° to COLON CA. |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>RENAL FAILURE  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>1/18/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BOWEL OBSTRUCTION  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16 19 79 to 1/22 19 79, that (I) (we) last saw the deceased alive on 1/22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br>Paul H. Seigel MD   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL H. SEIGEL MD  |  | 22e. ADDRESS<br>UNIV. OF MD. HOSP.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial   |  | 23b. DATE<br>1/25/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Old Blenheim   |  |
| 23d. LOCATION<br>BALTO. COUNTY, MD.   |  | 23e. DATE REC'D. BY REGISTRAR<br>JAN 29 1979   |  | 23f. REGISTRAR'S SIGNATURE<br>[Signature]  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evans Funeral Chapel  |  | 24b. ADDRESS<br>2325 York Road   |  |  |  |

79-01323

11

XXXXXX  
XXXXXX

44

Aug 3 1973

White

Female

XX

Baltimore, City

USA

Maryland

Baltimore University of Md. Hospital Keyrunch Ave. U.S.A.

1933 East Hill Road Baltimore, Md. 21204

Ann's Family

Louis K. Hilsenrath

Robert L. Taffel

212 30 2222

212

1973-08-03

1973-08-03

1973-08-03

1973-08-03

1973-08-03

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 01324

|   |  |   |  |   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
|---|--|---|--|---|--|------------------------------------|--|--|--|-------------------|--|--------------------------------------|--|-------|--|----------|--|------|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST                               |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH             |  | DAY                                  |  | YEAR  |  | 2b. HOUR |  |      |  |            |  |
| Zopito  |  |   |  |   |  | Salone                             |  | XX   |  | 1                 |  | 8                                    |  | 19    |  | 79       |  |      |  |            |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.                               |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY      |  | YEAR |  | 2d. HOUR   |  |
| male  |  | white   |  | Jan 22, 1922  |  | 56 YRS                             |  |  |  |                   |  | 1                                    |  | 8     |  | 19       |  | 79   |  | 11:40 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED                      |  | WIDOWED                                      |  | DIVORCED          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |          |  |      |  |            |  |
| Pescara, Italy  |  | USA   |  | X   |  |                                    |  |  |  |                   |  | Baltimore City                       |  |       |  |          |  |      |  | MD.        |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| Baltimore   |  | Mercy Hospital  |  | Presser - Labor   |  | Clothing                           |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?           |  | 13e. STREET ADDRESS                          |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| Maryland  |  | -----   |  | Baltimore   |  | YES X NO                           |  | 1011 Stiles Street                           |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| FIRST   |  | MIDDLE  |  | LAST  |  | FIRST                              |  | MIDDLE                                       |  | LAST              |  |                                      |  |       |  |          |  |      |  |            |  |
| Carmine   |  | Salone  |  |   |  | Annazopita                         |  | D'Amario                                     |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS                            |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| No  |  | 219-28-4109   |  | Mary D. Salone  |  | 1011 Stiles Street                 |  | 21202  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I DEATH WAS CAUSED BY:                                 |  | IMMEDIATE CAUSE (a)   |  | Ruptured abdominal aortic aneurysm |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 4413  |  |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF     |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |   |  |   |  | (b)                                |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
|   |  |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF     |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
|   |  |   |  |   |  | (c)                                |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  |   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  | YES                                |  | XX   |  | NO                |  |                                      |  |       |  |          |  |      |  |            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                    |  |   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN                       |  | COUNTY                                       |  | STATE             |  |                                      |  |       |  |          |  |      |  |            |  |
| NOT WHILE AT WORK   |  |   |  | STREET  |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an   |  | Autopsy   |  | XX  |  | Inspection                         |  | Inquiry                                      |  | and in my opinion |  |                                      |  |       |  |          |  |      |  |            |  |
| death resulted from:  |  | Natural causes  |  | XX  |  | Accident                           |  | Suicide                                      |  | Homicide          |  | Undetermined manner                  |  |       |  |          |  |      |  |            |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| Hormez R. Guard, M.D.   |  | Assistant   |  | 1/9/79  |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  |   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| Hormez R. Guard, M.D.   |  | 111 Penn Street, Balto, MD 21201                            |  |   |  |                                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                      |  | CITY OR TOWN                                 |  | COUNTY            |  | STATE                                |  |       |  |          |  |      |  |            |  |
| Burial  |  | Jan 12, 1979  |  | Holy Redeemer Cem   |  | Baltimore, Maryland                |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE         |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |
| Dippel Brothers, Inc.   |  | 7110 Belair Rd. 21206                                       |  | JAN 10 1979   |  | Hormez R. Guard                    |  |  |  |                   |  |                                      |  |       |  |          |  |      |  |            |  |

45810-27

Released by MCO as non-Med in DR - 3244 per Mr. Henry  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 79-01325<br>REG. NO.  |                   |
|---|--|---|--|---|-------------------|
| 1. FOR STATE REGISTRAR  |  |   |  |   |                   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>James Edward Sampson   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>01/16/79 |   | 2b. HOUR<br>6:40p |
| 3. SEX<br>male  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 23, 1968  |                   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>10   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Maryland City MD.                             |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none                           |                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>none   |                   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Howard   |  | 13c. CITY OR TOWN<br>W. Friendship  |                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William E. Sampson   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nancy O'Donnell   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>none  |  | 17. INFORMANT<br>2620 Pfefferkorn Road<br>Wm. E. Sampson West Friendship, Md. 21794             |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>7468<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aortic valve disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aortic valve endocarditis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u><br><u>since birth</u><br><u>6 mos</u> |  |   |  |   |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                   |
| 19a. DATE OF OPERATION<br>1-16-79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bacterial endocarditis  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-15, 1979, to 1-16, 1979, that (I) (we) lost the deceased alive on 1-16-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                   |
| 22b. SIGNATURE<br>J. J. Badner  |  |   |  | 22c. DATE SIGNED<br>1-16-79   |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial   |  | 23b. DATE<br>1/19/1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Mem. Gardens                                    |                   |
| 24. FUNERAL DIRECTOR NAME<br>SLACK Funeral Home, Ellicott City, Maryland 21043  |  | 24b. DATE REC'D. BY REGISTRAR<br>JAN 22 1979  |  | 24c. REGISTRAR'S SIGNATURE<br>L. J. McCready  |                   |
| 24a. ADDRESS  |  | 24b. DATE REC'D. BY REGISTRAR   |  | 24c. REGISTRAR'S SIGNATURE  |                   |

25810-81



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 79-01326   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LILLIE M. (LEWIS) SANDERS   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 25, 1979  |  |  |  |
| 3. SEX<br>Female  |  |  |  | 4. RACE<br>Negro   |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 22 1929   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL              |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |
| 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13e. STREET ADDRESS<br>1625 Ensor Street  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Lewis  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myrtle Green  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-20-2242  |  |  |  |
| 17. INFORMANT<br>Myrtle Gillard   |  |  |  | ADDRESS<br>912 East Biddle Street  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4275<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Massive hemoptysis</u><br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1h 10min</u><br><u>1h 14min</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>79</u> , to <u>1/25</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>P. Campodiano MD</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1/25/79</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>P. Campodiano</u>   |  |  |  | 22e. ADDRESS<br><u>Johns Hopkins Broadway</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/29/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Roberts</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-01327

|   |                         |  |  |   |   |
|---|-------------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SYLVIA S. SANDLER</b>  |                         | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 20 79</b>  |  | 2b. HOUR <b>9:35 PM</b>   |   |
| 3 SEX <b>FEMALE</b>   | 4 RACE <b>CAUCASIAN</b> | 5 DATE OF BIRTH MONTH DAY YEAR <b>3 13 1916</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |                         | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>   |   |
| 13a STATE <b>MD</b>   |                         | 13b COUNTY <b>Balt</b>   |  | 13c CITY OR TOWN <b>Balt</b>  |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM</b>   |                         | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE MORRIS</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |                         | 16b SOCIAL SECURITY NO. <b>214 01265</b>   |  | 17 INFORMANT ADDRESS <b>HERBERT SANDLER 6605 SHELBRICK PL. #21209</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac arrest</b>   |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>4275</b>  |                         |  |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |                         |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Severe Arteriosclerosis</b>  |                         |  |  |   |   |
| 19a DATE OF OPERATION   |                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                         |  |  |   |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 19 79</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |                         | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION CITY OR TOWN COUNTY STATE  |   |
| 22a I certify that (I) <del>(the hospital)</del> attended the deceased from <b>11/19/79</b> , 19 <b>79</b> , to <b>1/20</b> , 19 <b>79</b> , that (I) <del>(we)</del> lost <del>(saw)</del> the deceased alive on <b>1/19/79</b> , 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |                         |  |  |   |   |
| 22b SIGNATURE <b>Stanley M. Rosen</b>   |                         | DEGREE <b>MD</b>   |  | 22c DATE SIGNED <b>1/20/79</b>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY M. ROSEN, M.D.</b>  |                         | 22e ADDRESS <b>SINAI HOSPITAL</b>  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                         | 23b DATE <b>JAN. 22, 1979</b>  |  | 23c NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>  |   |
| 23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>  |                         | 23e NAME OF CEMETERY OR CREMATORY  |  |   |   |
| 24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>   |                         | 24b ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  | 25a DATE REC'D. BY REGISTRAR <b>JAN 23 1979</b>   |   |
| 25b REGISTRAR'S SIGNATURE <b>Dorothy Kelly</b>  |                         |  |  |   |   |

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72-01357





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 79-01328<br>REG. NO. |  |
|---|--|---|--|--|--|--|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |  |  |  |                      |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ROBERT L SANSBURY   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 25 79  |  | 2b. HOUR<br>10 07 A.M.   |  |                      |  |
| 3 SEX<br>male   |  | 4 RACE<br>cauc  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>6 9 30   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>City of BALTIMORE MD.   |  |  |  |                      |  |
| 10 CITY OR TOWN OF DEATH<br>Balto   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)<br>Cable Splicer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Rspco   |  |                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |  |  |  |  |                      |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>Prince Geo.  |  | 13c. CITY OR TOWN<br>Pleasant Hills  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3904 Canterbury Way   |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Sansbury   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katie Thorne   |  |  |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES KOREA  |  |   |  | 16b. SOCIAL SECURITY NO<br>577-44-0017   |  | 17. INFORMANT ADDRESS<br>MARY LOU SANSBURY SAME AS ITEM 13   |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Renal Failure<br>2050 DUE TO, OR AS A CONSEQUENCE OF<br>b) Acute Myelogenous Leukemia 2 weeks<br>DUE TO, OR AS A CONSEQUENCE OF<br>c) Poorly Differentiated Lymphoma; Pulmonary Infarcts |  |   |  |  |  |  |  |  |  |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a  |  |   |  |  |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12/79 to 1/25/79, that (I) (we) last saw the deceased alive on 1/25/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |   |  |  |  |  |  |  |  |                      |  |
| 22b. SIGNATURE<br>Richard C. Stephenson   |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/25/79  |  |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD C STEPHENSON   |  |   |  | 22e. ADDRESS<br>22 S. Greene St., BCRC, Balto., Md   |  |  |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1-29-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WASH. NATIONAL CEM   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>SUITLAND MD   |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME<br>G.P. KALAS   |  |   |  | ADDRESS<br>6160 OXON HILL RD. OXON HILL, MD  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 30 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |                      |  |

10-01358

10-01358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |                                    | 79-01329                                     |  |
|--|--|--|--|---|---|--|--|--|------------------------------------|--|--|
| FOR<br>1 - STATE REGISTRAR   |  |  |  |   |   |  |  |  |                                    | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FLORITA M. SANTANA</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/14/79</b>           |  |  | 2b. HOUR<br><b>12:45 PM</b>  |                                    |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 15, 1911</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |                                    |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>413 S. Register Street</b>   |                                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Banda</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnecia</b> |  |  |  |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-28-0910</b>   |  | 17. INFORMANT ADDRESS<br><b>Pedro Santana 413 S. Register Street</b>  |   |  |  |  |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes mellitus</b><br>2500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |  |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |  |  |  |                                    |  |  |
| 19a. DATE OF OPERATION<br><b>1-9-79.</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ulcer of Toes RT.</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                    |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1-14</b> , 19 <b>79</b> , to <b>1-14</b> , 19 <b>79</b> , that (we) lost saw the deceased alive on <b>1-14</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) view the body after death.  |  |  |  |   |   |  |  |  |                                    |  |  |
| 22b. SIGNATURE<br><b>H. S. Lee M.D.</b>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>1-14-79</b> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOA S. LEE</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL</b>   |  |  |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1-17-1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross</b>         |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel County, Maryland</b>   |                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zailer Inc. 1901-07 Eastern Avenue</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>  |                                    |  |  |

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COPIES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M/7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |                     | 79-01330<br>REG. NO.   |  |
|---|--|---|--|---|--|---|--|---|---------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  |   |  |   |                     |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John G. Sapp   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 27-79                                  |  |   | 2b. HOUR<br>11:05 M |  |  |
| 3 SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 30, 1903   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 years YRS                                 |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |                     | 7. IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                     |  |   |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF KNOWN IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK AND MOST OF WORKING LIFE)<br>Maintenance |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Bethlehem                      |                     |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Sapp   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve Clarke               |  |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-09-9273   |  | 17. INFORMANT<br>ADDRESS<br>Mr. John J. Sapp, 2677 Wilkens Avenue 21223         |  |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>heart failure</u><br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>2° Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |   |                     |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)  |  |   |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |                     |  |  |
| 22b. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED  |  |   |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Naylo  |  |   |  |   |  | 22e. ADDRESS  |  |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>1/31/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard County, Maryland     |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.,   |  |   |  | ADDRESS<br>Balto. Md. 21229   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1979                                    |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                 |                     |  |  |

2005

08310-05

#1 65271/16/79 gj

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01331  
REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helen M. SCANLON Scanlan   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 10, 1979 |   |  | 2b. HOUR<br>2:30 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 20, 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick Scanlan   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary A. Moran   |   | 13e. STREET ADDRESS<br>607 Sommerset Ave. # 4   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, AND OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-46-2917   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Albert W. Thorpe Same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>C.I.A.</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 days |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>1964 to 1979  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1964 to 1979   |  | 21g. DATE SIGNED<br>11 Jan 79  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8 days</u> to <u>10 Jan</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8 days</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Dr. William G. Helfrich</u>  |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11 Jan 79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William G. Helfrich, M.D.  |  | 22e. ADDRESS<br>5006 Roland Avenue Balto., Md.   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/13/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |  |   | 25a. DATE REC'D BY REGISTRAR<br>JAN 10 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry W. Jenkins</u>  |  |

10010-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The following is a copy of the death certificate. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

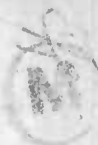
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01332

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | JANUARY / 23 / 79  |  | 2 <sup>00</sup> AM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | White   |  | MONTH DAY YEAR<br>May 26 1913  |  | 65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Md.  |  | U.S.A.  |  |  |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Balto.   |  | JOHNS HOPKINS HOSPITAL  |  | Firefighter  |  | Balto City  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS   |  |
| Md.  |  |   |  | Balto.   |  | 702 N. Glover St.   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES   |  | 16b. SOCIAL SECURITY NO.  |  |
| Charles  |  | Elizabeth   |  | no   |  | 216-03-8471   |  |
| 17. INFORMANT  |  | 18. ADDRESS   |  | 19. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| Marie Schaefer (wife)  |  | same address  |  | 1/18/79  |  | Tracheostomy  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | 22a. SIGNATURE   |  | 22b. DATE SIGNED  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>  |  | 5 minutes   |  | Anna Mae Diehl MD  |  | 1/23/79   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Anoxic Brain Damage</u>                   |  | 10 days   |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22d. ADDRESS  |  |
| (c) <u>Previous cardiopulmonary arrest</u>   |  | 10 days   |  | Anna Mae Diehl   |  | Johns Hopkins Hospital  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  | Gram positive septicemia  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  |
|  |  |   |  | Burial   |  | 1/26/79   |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | Gardens of Faith   |  | Balto. COUNTY MD.   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
|  |  | P.M. 19   |  |  |  |   |  |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from 1/12, 19 79, to 1/23, 19 79, that (I) (we) lost saw the deceased alive on 1/23, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE  |  |
|  |  |   |  |  |  | 22c. DATE SIGNED  |  |
|  |  |   |  |  |  | 1/23/79   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24a. ADDRESS  |  | 24b. DATE REC'D. BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE  |  |
| Schimunek Funeral Home, Inc.   |  | 2331 Brehms Lane Balto. Md. 21213   |  | JAN 23 1979  |  | [Signature]   |  |

10-01335



10-01335

10-01335





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  | 79-01333   |                        |  |
|--|--|--|--|---|--|---|---|--|--|--|------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |   |   |  |  |  |                        |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ALFRED T. SCHAEFER</b>  |  |  |  |   | 2a. DATE OF DEATH  |   | MONTH<br><b>1-4-79</b>  |  | DAY<br><b>10</b>   |  | YEAR<br><b>07 A.M.</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> / DAY <b>16</b> / YEAR <b>196</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                               |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                            |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>               |   |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |
| 13a. STATE<br><b>MD</b>  |  |  |  |   | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2823 HAMPTON AVE</b>   |  |                        |  |
| 14. FATHER'S NAME<br>FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>       |   |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>WW</b>  |   | 17. INFORMANT<br><b>WIFE</b>  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-pulmonary Arrest.</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease, Congestive Heart Failure</b><br>SEVERAL YEARS |  |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS</b> |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/78</b> , 19____, to <b>1/4/78</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |   |   |  |  |  |                        |  |
| 22b. SIGNATURE<br><b>S.B. Kraus M.D.</b>   |  |  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/4/79</b>                            |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S.B. KRAUS, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL.</b>                                |   |   |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>1/8/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PK.</b>                      |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO, MD</b>   |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Paul E. Charnow 3rd</b> ADDRESS <b>3617 Chestnut Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1979</b>                             |   | 25b. REGISTRAR'S SIGNATURE<br><b>morris m. m. m.</b>  |  |  |  |                        |  |



10-01333

REGISTER

ALBERT

UNION MEMORIAL HOSPITAL

MEMORIAL

UNION MEMORIAL HOSPITAL

MEMORIAL

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

79-01334

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>CATHERINE - SCHAROUN</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 19, 1979</b>  |  | 2b HOUR<br>M  |   |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 18, 1912</b>                          |   |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>   |  | 7a BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b>  |  | MD  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE 13b COUNTY<br><b>Maryland -</b>   |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |   |
| 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>3404 Ramona Avenue 21213</b>  |  |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Koenigbauer</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>215-09-4189</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Frank Scharoun (husb.) same as 13</b>                 |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Failure</b><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b><br>3y.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b><br>5y. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Cancer of the Breast &amp; pleural metastases</b><br>3y.   |  |  |  |   |   |
| 19a DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Jan 15</b> , 19 <b>75</b> to <b>Jan 19</b> , 19 <b>79</b> ; that (I) (we) lost<br>saw the deceased alive on <b>Jan 29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death.   |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Dr. George Richards</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/22/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. George Richards, M.D.</b>   |  | 22e. ADDRESS<br><b>G.B.M.C., Towson, Md.</b>   |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/23/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cem.</b>                      |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>M Baltimore, Md.</b>   |  |  |  |   |   |
| 24 FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  | 3321 Brehms Lane<br>Balto. Md. 21213   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1979</b>                                 |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>  |  |  |  |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-01334



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-01335

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |   |  |  |
|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RUTH W SCHAUER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 3 79 |   |  | 2b. HOUR<br>10-05A   |   |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 23 19   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 Years |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tenn. USA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOOD SAMARITAN HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>A&P clerk        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food Store  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  |   | 13b. CITY OR TOWN<br>BALTIMORE  |  | 13c. STREET ADDRESS<br>300 BRYANSTONE ROAD   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN A WEBB  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ALTA Burrell   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>413-16-3499  |   | 17. INFORMANT<br>ADDRESS 105 Birdwood Ave.<br>Robt. T. McDonald Catonsville, Md.  |  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiogenic Shock<br>1370<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Tension Pneumothorax Probable<br>(c) H/O T.B. Inactive<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days |  |  |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>chronic obst. Lung disease  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1978, to 1/3, 1979, that (I) (we) lost<br>saw the deceased alive on 1/3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br>H. Patel   |  |  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br>1/3/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>INDU PATEL, M.D.  |  |  |   | 22e. ADDRESS<br>H. NEWBALL, M.D. GOOD SAMARITAN HOSPITAL  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>JAN. 5, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. J. Schmitt  |  |  |   | ADDRESS<br>Owings Mills, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>T. J. Kelly  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

20010-01



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01336

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY SCHEFERMAN</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JAN 5 79</b>   |  | 2b. HOUR<br><b>2 05 PM</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 22 23</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeping</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Woodlawn</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles W. Jackson</b>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Fredia Amelia Dietz</b>                                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-4558</b>  | 17. INFORMANT ADDRESS<br><b>Mr. Howard J. Scheferman</b><br><b>2124 Southland Rd. Woodlawn, Md. 21207</b> |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTATIC OVARIAN CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b> |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ASCITES PLEURAL EFFUSION, G.I. BLEED</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>1/5/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/5/79</b> to <b>1/5/79</b> , that (1) (we) last saw the deceased alive on <b>1/5/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Leonard Lichter</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1/5/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. LEONARD LICHTER</b>  |  | 22e. ADDRESS<br><b>2435 W. BALTIMORE AVE BALTO MD 21215</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/8/79</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Carroll Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, P.A.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>                            |   |
| 8728 Liberty Road Randallstown, Md. 21133   |  |   |   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES

DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

WASHINGTON, D.C.

SEP 10 1964

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01337  
REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>THERESIA D. SCHENDEL</b>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-5-79</b>   |   | 2b. HOUR<br><b>648</b> M                             |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>WHITE</b>  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>11 22 07</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD                                      |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Vol Md Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY                    |
| 13a. STATE<br><b>MD</b>  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS<br><b>6718 Lachlan Circle</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>EUGENE RICHARD FISCHER</b>  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>DOROTHEA KALBSLEISCH</b>                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216.32.4066</b>   |   | 17. INFORMANT ADDRESS<br><b>Orange, Va. 22960</b><br><b>Gordon N. Schendel, Jr. 236 Caroline ST</b> |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardioresp arrest</b><br>1419<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca of tongue</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>1/5/79</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>19</b>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/5/79</b> to <b>1/5/79</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/5/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>NEW MD</b>  |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1/5/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NEW</b>  |   | 22e. ADDRESS<br><b>Vol Md Hosp</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |   | 23b. DATE<br><b>1/8/1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  |
| 23d. LOCATION CITY OR TOWN<br><b>Baltimore</b>   |   | COUNTY<br><b>Md.</b>   |   | STATE<br><b>Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Brooks Bradley Inc. Balto., Md</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lisney McCready</b> |

10-01331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 79-01338                                     |  |       |  |          |  |
|--|--|--|--|--|--|---|--|--|--|--|--|-------|--|----------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  |  |  |   |  |  |  | REG. NO.                                     |  |       |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | MONTH  |  | DAY  |  | YEAR  |  | 2b. HOUR |  |
| HERMAN   |  |  |  |  |  | SCHER   |  | 1  |  | 27   |  | 79    |  | 237A M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                              |  |       |  |          |  |
| MALE   |  | CAUCASOID  |  | MONTH DAY YEAR<br>10 25 1909   |  | 78 76 YRS.  |  | MONTHS   |  | DAYS   |  | HOURS |  | MIN      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |       |  |          |  |
| Lithuania  |  | USA  |  |  |  | BALTIMORE CITY MD.  |  |  |  |  |  |       |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |       |  |          |  |
| BALTIMORE  |  | SINAI HOSPITAL - BALTIMORE   |  | Printer  |  | Printing  |  |  |  |  |  |       |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. COUNTY  |  | 13d. CITY OR TOWN   |  | 13e. STREET ADDRESS  |  |  |  |       |  |          |  |
| Maryland   |  | Balto.   |  | Owings Mills   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 314 Garrison Forest Rd 21117                                   |  |  |  |       |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |       |  |          |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| Albert Scher   |  | Bessie Cohen   |  |  |  |   |  |  |  |  |  |       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |       |  |          |  |
| No   |  | 164-12-3474  |  | Mr. Ephraim Winer-   |  | 314 Garrison Forest Rd  |  |  |  |  |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |       |  |          |  |
| PART I. DEATH WAS CAUSED BY  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| 496- DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| (b) COPD, Congestive Heart Failure   |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| (c)  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |       |  |          |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |  |  |       |  |          |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |  |       |  |          |  |
|  |  | P.M.   |  | 19   |  |   |  |  |  |  |  |       |  |          |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |  |  |       |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |       |  |          |  |
|  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 10 19 79 to JAN 27 19 79, that (we) last saw the deceased alive on JAN 27 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |  |  |       |  |          |  |
| Philip Jay Schwartz MD.  |  |  |  | 1/27/79  |  |   |  |  |  |  |  |       |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |       |  |          |  |
| PHILIP JAY SCHWARTZ  |  | SINAI HOSPITAL - BALTIMORE   |  |  |  |   |  |  |  |  |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |  |  |       |  |          |  |
| Burial   |  | Jan 28/79  |  | Ohef Yakov   |  | Baltimore, Md/  |  |  |  |  |  |       |  |          |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |  |  |       |  |          |  |
| NAME   |  | FEB 1 1979   |  | [Signature]  |  |   |  |  |  |  |  |       |  |          |  |
| [Signature] SOL. LEVINSON  |  |  |  |  |  |   |  |  |  |  |  |       |  |          |  |

83310-07

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01339

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS SCHEUERMAN</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 30, 1979</b> |  |  | 2b. HOUR <b>M</b>  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 22, 1997</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>   |  | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST <b>CHARLES</b> MIDDLE <b>G.</b> LAST <b>SCHUEERMAN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>COUSEN</b> LAST <b>COUSEN</b>   |  | 13e. STREET ADDRESS <b>4405 MARBLE HALL RD. 21236</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO. <b>381-05-1219</b>   |  | 17. INFORMANT ADDRESS <b>ELIZABETH SCHEUERMAN, 4405 MARBLE HALL 21236</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>4280<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Severe Emphysema - Smoking</b>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/15/78</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>STREET</b>   |  | 21f. LOCATION CITY OR TOWN <b>GREEN MOUNT</b> COUNTY <b>MD.</b> STATE <b>MD.</b>   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/15/78</b> to <b>1/30/79</b> , that (I) (we) lost saw the deceased alive on <b>1/20/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/30/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUONG NGUYEN</b>  |  | 22e. ADDRESS <b>6 Linlow Ct Town 21204</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>31 JAN 79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEM.</b>   |  | 23d. LOCATION CITY OR TOWN <b>TSHOO</b> COUNTY <b>MD.</b> STATE <b>MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>CLARETCH FUNERAL HOME, BALTO MD 21206</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-01330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 79-01340<br>REG. NO. |  |
|--|--|--|--|---|--|--|--|---|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Harold Schilling</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/22/79</b>  |  | 2b. HOUR <b>11 22 AM</b>  |  |                      |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>9-14-98</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>  |  |                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                      |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN   |  | 13e. STREET ADDRESS <b>7725 OLD NORTH PT. RD.</b>  |  |   |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES SCHILLING</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>                                    |  |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>1 WVI</b>  |  | 17. INFORMANT <b>BCH RECORDS: 4940 EASTERN AVE. BALTIMORE, MD. 21224</b>  |  |  |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myocardial Infarction</b>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |                      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/19</b> 19 <b>79</b> to <b>1/22</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |                      |  |
| 22b. SIGNATURE <b>David Mishkin</b> MD   |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>1/22/79</b>   |  |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Mishkin</b>   |  |  |  | 22e. ADDRESS <b>Balto. City Hosps</b>   |  |  |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1-26-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cn</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md</b>                              |  |   |  |                      |  |
| 24. FUNERAL DIRECTOR NAME <b>Raymond L. Kaczorowski</b> ADDRESS <b>2525 Meeth St.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Robert M. Hardy</b>  |  |   |  |                      |  |

MEDICAL CERTIFICATION



04010-05

BALTIMORE CITY

DEPARTMENT OF THE ARMY

WASHINGTON

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D.C.

1000 EIGHTH AVE.  
WASHINGTON, D.C. 20004

FORWARDED TO YOU BY AIR

REGISTERED MAIL

POSTAGE WILL BE PAID BY ADDRESSEE

24

1000 EIGHTH AVE.

WASHINGTON, D.C. 20004

ATTENTION: ADJUTANT GENERAL

WASHINGTON, D.C.

20004

1000 EIGHTH AVE.

WASHINGTON, D.C. 20004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 79-01341<br>REG. NO.   |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 7b. HOUR   |  |
| Emanuel   |  | J.   |  | SCHISSLER  |  |  |  | January 22, 1979  |  | 7:00 A M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                                |  |
| Male  |  | White  |  | Nov. 2, 1901   |  | 77 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Maryland  |  | USA  |  |  |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |
| Baltimore   |  | 4668 Kernwood Avenue   |  |  |  |  |  | Builder   |  | Self.-Emp.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS  |  |
| Maryland  |  |  |  | Baltimore  |  |  |  |   |  | 4668 Kernwood Avenue                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| George Schissler  |  |  |  | Elizabeth Binder   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| No  |  | 215-03-1731  |  | Mrs. Beverly Clark Towson, Md.   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Yes</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>78</u> , to <u>June 22</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>Nicholas Fortuin</u> DEGREE <u>MD</u>   |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>1-22-79</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Nicholas Fortuin, M.D.</u>   |  |  |  |  |  | 22e. ADDRESS <u>11 E. Chase St. Balto., Md.</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
| Burial  |  | 1/24/79  |  | Loudon Park  |  | Balto.,  |  |   |  | Md.  |  |
| 24. FUNERAL DIRECTOR <u>Henry W. Jenkins &amp; Sons Co.</u>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <u>Petry Helms</u>   |  |  |  |
| 4905 York Rd. Balto., Md. 21212   |  |  |  |  |  | JAN 23 1979  |  |   |  |  |  |

10-01371

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |  |   | 79-01342 |  |
|---|--|---|--|--|--|--|---|--|---|----------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |   |  |   | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>DANIEL LEE Schloss  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 17 79                     |  |   | 2b. HOUR<br>4:40 P.M.  |   |          |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 13 08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |  |   |          |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF-EMPLOYED  |   | 15. KIND OF BUSINESS OR INDUSTRY<br>LUMBER   |   |          |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>APT. 311<br>7111 Park Heights Ave #21215 |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>TONEY SCHLOSS   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA ROSENZWOG |  |   |  |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>214-26-4442   |  | 17. INFORMANT<br>MRS. ROSE SCHLOSS<br>7111 PARK HTS. AVE., APT. 311 #21215   |  |  |   |  |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest<br>4331<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>b. Complete occlusion of Lt. Internal Carotid art.<br>DUE TO, OR AS A CONSEQUENCE OF<br>c.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |   |  |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |   |  |   |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15, 1979, to 1/17, 1979, that (I) (we) lost saw the deceased alive on 1/17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |  |   |          |  |
| 22b. SIGNATURE<br>F. B. Neasman, II MD  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>1/17/79  |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>F. B. NEASMAN, II MD   |  |   |  |  | 22e. ADDRESS<br>Sinai Hosp. of Balto.                              |  |   |  |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 19, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO   |  | 23d. LOCATION<br>BALTIMORE   |   | COUNTY MARYLAND  |   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1979                       |  | 25b. REGISTRAR'S SIGNATURE<br>Pitney K. Keady   |  |   |          |  |

18-01345

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 60M 1/75  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT)<br>IRMA L. SCHMIDT  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>1 1 1979   |  | 2b HOUR<br>1003p M  |  |
| 3 SEX<br>female  |  | 4 RACE<br>caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>4 15 1908  |  | 6 AGE *IN YEARS (LAST BIRTHDAY)<br>70 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Germany  |  | 7b CITIZEN OF WHAT COUNTRY?<br>Germany  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore, Md  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>US PUBLIC HEALTH SERVICE HOSPITAL                |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife           |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br>PENNSYLVANIA  |  | 13b COUNTY<br>EAST BERLIN   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br>Rd 2, box 61  |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Friedrich Kundesky   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Barbara Hack  |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b SOCIAL SECURITY NO.<br>none   |  | 17 INFORMANT ADDRESS<br>21718<br>Raymond Head, Box 206, Burkittsville, Md.   |  |   |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiopulmonary arrest<br>1533 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) metastatic adenoca of sigmoid colon<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min<br>3 mon from diagnosis |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a I certify that (I) this hospital attended the deceased from Dec 15, 1978 78 to Jan 1 19 79, that (I) (we) lost saw the deceased alive on Jan 1 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)   |  |   |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><i>Curt Clogston</i>  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c DATE SIGNED<br>Jan 1, 1979  |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Curt Clogston  |  | 22e ADDRESS<br>3100 Wyman Pk. Dr., Balto. MD 21211  |  |  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  | 23b DATE<br>01-03-79  |  | 23c NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CREM.   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                   |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.   |  | ADDRESS<br>4107 WILKENS AVE.  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 4 1979   |  | 25b REGISTRAR'S SIGNATURE<br><i>Anthony M. C...</i>                                 |  |   |  |

3-01343





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |   |  | 79-01344                                     |  |
|---|--|---|--|---|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |   |  |  |   |  | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MILDRED MIDDLE R. LAST SCHMIDT  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 24, 1979               |  |  | 2b. HOUR<br>3:00 PM   |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>/Oct. 19, 1900   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6700 Cannongate Rd. |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>counselor, retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bd. of Education   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY  |  |   |  |   | 13c. CITY OR TOWN<br>Balto.                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>6700 Cannongate Rd.     |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Rev. Lemuel S. Reichard  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Florence Hayward  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  |   | 16b. SOCIAL SECURITY NO.<br>214-36-7978  |   | 17. INFORMANT ADDRESS<br>Dorothy Jackson 8309 Harford Rd. 21234 |  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of ascending colon<br>DUE TO, OR AS A CONSEQUENCE OF (b) metastatic to liver<br>DUE TO, OR AS A CONSEQUENCE OF (c) obstructive jaundice + liver coma<br>1536         |  |   |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>June 1977   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of ascending colon |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/12/77, 19 to 11/24, 1979, that (I) (we) saw the deceased alive on 11/22/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Dr. Donald W. Mintzer M.D.  |  |   |  |   | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/24/79                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Donald W. Mintzer  |  |   |  |   | 22e. ADDRESS<br>3009 Evergreen Ave., Balto, Md.                 |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial   |  |   | 23b. DATE<br>Jan. 27, 1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park               |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.  |  |   |  |   | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy |  |  |

#E10-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |  |  |   |  | 79-01345<br>REG. NO.   |  |
|---|--|-------------------------|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST <u>Marion</u> MIDDLE <u>Ethel</u> LAST <u>Schoenhut</u>   |  |                         |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH DAY YEAR<br><u>1</u> <u>30</u> <u>1979</u>  |  | 2b. HOUR<br><u>1:15P</u>   |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>White</u> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>June 7, 1911</u>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><u>67</u> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><u>1</u> <u>30</u> <u>1979</u>                     |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Pennsylvania</u>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City,</u> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore City</u>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>St. Agnes Hospital</u> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Homemaker</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>Maryland</u>   |  |                         |  | 13b. CITY OR TOWN<br><u>Baltimore</u>   |  | 13c. CITY OR TOWN<br><u>Catonsville</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><u>6263 Gilston Park Road 21228</u>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>William J. Downs</u>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Margot Maude Edwards</u>                   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><u>no</u>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><u>219-28-8816</u>  |  | 17. INFORMANT ADDRESS<br><u>William F. Schoenhut, 6263 Gilston Pk Rd. 21228</u>                |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal hemorrhage</u><br>5789<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>BODY ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>Thomas D. Smith</u>  |  |                         |  | TITLE (SPECIFY)<br><u>Deputy Chief</u>  |  |  |  | DATE<br>SIGNED <u>1/31/79</u>   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><u>Thomas D. Smith, M.D.</u>  |  |                         |  | ADDRESS<br><u>111 Penn St. Balto., MD.</u>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |  |                         |  | 23b. DATE<br><u>2/2/79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westview Memorial Pk</u>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonsville, Balto., Md.</u>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>1630 Edmondson Ave., Catonsville, Md.</u>  |  |                         |  |   |  |  |  |   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 5 1979</u>  |  |                         |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony A. Cready</u>   |  |   |  |  |  |

20-01342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 79-01346<br>REG. NO.   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> LILLIAN <sup>MIDDLE</sup> A. <sup>LAST</sup> SCHOLLIAN  |  |  |  | January 7, 1979 M  |  |   |  |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 - 07 - 00   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 78  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2720 Pelham Avenue                      |  |   |  |
| 14. FATHER'S NAME <sup>FIRST</sup> John <sup>MIDDLE</sup> J. <sup>LAST</sup> Bransby  |  |  |  | 15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Emma <sup>MIDDLE</sup> <sup>LAST</sup> Higdon  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 444-90-4235   |  | 17. INFORMANT Son ADDRESS Mr. William J. Yeager 6607 Moyer Avenue  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE TUBULAR NECROSIS   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr.   |  |
| 4280 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EDEMA   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CIRCUMSTANCES FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-7-1979 to until death, that (I) (we) last saw the deceased alive on 1-7-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE Vittal Reddy   |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VITTAL REDDY  |  |  |  | 22e. ADDRESS GOOD SAMARITAN HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 1-11-1979  |  | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 9 1979   |  | 25b. REGISTRAR'S SIGNATURE  |  |

28-01346

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01347

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Arthur Daniel SCHRAMM</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 1, 1979</b>                            |  | 2b. HOUR<br>M<br><b>AM</b>                                |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 24, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6018 Harford Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cashier-Clerk</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Motor Veh. Ad</b> |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>-----</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Schramm</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Iida Mattill</b>                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Lewis Ellis 6018 Harford Rd. 21214</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 75</b> to <b>19 78</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 10, 19 78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |   |  | 22c. DATE SIGNED<br><b>Jan 3, 1979</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NESTOR M. CARUONA</b>   |   |   |  | 22e. ADDRESS<br><b>6012 Harford Rd. Balto. Md. 21214</b>                             |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |   | 23b. DATE<br><b>Jan 5, 79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Dippel Brothers, Inc. 7110 Belair Rd. 21206</b>  |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |   |                                   |  | 79-01348<br>REG. NO.                         |  |
|---|--|--|--|--|---|--|---|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |   |                                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH   |  |   |                                   |  | 2b. HOUR                                     |  |
| FIRST M. I. LAST SCHREIBER  |  |  |  |  | MONTH 1 - DAY 25 - YEAR 79  |  |   |                                   |  | 4:20 AM                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |
| male  |  | WHITE  |  | MONTH 4 - DAY 22 - YEAR 90   |   | 88   |   | MONTHS                            |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                                   |  |  |  |
| Poland  |  | U.S.   |  |  |   | Balto, City MD.  |   |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Baltimore   |  | Levinson Hebrew Center + Hosp.   |  |  |   | BAKER  |   | FOOD                              |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. COUNTY                                      |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS  |  |  |
| MD  |  |  |  |  | Balto   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | APT. 617 #21215  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |                                   |  |  |  |
| FIRST UNKNOWN MIDDLE LAST SCHREIBER   |  |  |  |  | FIRST UNKNOWN MIDDLE LAST   |  |   |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |                                   |  |  |  |
| NO  |  |  |  |  | 070-03-5423   |  | MRS. LENA SCHREIBER 2500 W. BELVEDERE AVE., APT. 617 #21215         |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis c Rt hemiplegia   |  |  |  |  |   |  |   |                                   |  |  |  |
| 4279 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cerebro-vascular disease   |  |  |  |  |   |  |   |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrhythmia  |  |  |  |  |   |  |   |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |  |   |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY                              |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |                                   |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR                         |  |   |  |   |                                   |  |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY                             |  |   | 21f. LOCATION  |   |                                   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | STREET CITY OR TOWN COUNTY STATE   |   |                                   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 3/30/1976, to 1/25/1979, that (we) last saw the deceased alive on 4:20 AM 1/25/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (didn't) view the body after death. |  |  |  |  |   |  |   |                                   |  |  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE  |  |   |                                   |  | 22c. DATE SIGNED                             |  |
| KHIN M. TUN   |  |  |  |  | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |                                   |  | 1/25/79                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS  |  |   |                                   |  |  |  |
| KHIN M. TUN   |  |  |  |  | 2110 Pot Spring Road Md 21093   |  |   |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION                     |  |  |  |
| BURIAL  |  |  | JAN. 28, 1979                                    |  | BALTIMORE HEBREW  |  |   | CITY OR TOWN COUNTY STATE         |  |  |  |
|   |  |  |  |  |   |  |   | REISTERSTOWN, BALTO MD            |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |   | 25b. REGISTRAR'S SIGNATURE        |  |  |  |
| SOL LEVINSON & BROS., INC.  |  |  |  |  | FEB 1 1979  |  |   | [Signature]                       |  |  |  |
| NAME ADDRESS  |  |  |  |  |   |  |   |                                   |  |  |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215   |  |  |  |  |   |  |   |                                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01349

REG. NO.

|   |  |   |  |   |  |  |   |  |
|---|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Harry C Schroeder  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 4 79                          |   |  | 2b. HOUR<br>2:55PM   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 8 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dutchess  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Fred William Schroeder  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary M. Schamberger   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT UNKNOWN)<br>YES   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, ENTER WAR DATES)<br>214-16-3168   |   | 17. INFORMANT<br>Mrs. Muriel L. Schroeder<br>Wife<br>ADDRESS<br>3010 Virginia Ave.<br>Balto., Md.<br>21227 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) MYOCARDIAL INFARCTION.<br>(c) Atherosclerotic Cardiovascular Disease |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4, 1979, to 1/4, 1979, that (I) (we) last saw the deceased alive on 1/4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br>A. Osei-Wusu  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>1/4/79   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. OSEI-WUSU   |  |   |  |   |  | 22e. ADDRESS   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1/8/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully Funeral Home of Brooklyn   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>R. J. McCreedy   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01350  
REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Walter T. SCHROEDL   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 4, 1979                 |   |   | 2b. HOUR<br>5:45 P.M.  |   |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 20, 1895  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Longgreen Nursing Home |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Proprietor       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cleaners  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>1642 Kingsway Road                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Othello S. Schroedl   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Schaefer         |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-32-0101 |   | 17. INFORMANT<br>ADDRESS<br>Othello Schroedl Baltimore, Md.                                     |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis, generalized</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.<br>5 yr.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/1/79</u> to <u>1/5/79</u> , that (I) (we) last saw the deceased alive on <u>12/19/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Norman R. Freeman M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |   | 22c. DATE SIGNED<br>1/5/79   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Norman Freeman, M.D.   |  |   |  |   |   | 22e. ADDRESS<br>11 W. 29th Street Balto., Md.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1/8/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

10-01320



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 79-01351<br>REG. NO.  |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BETTY ELIZABETH SCHULMAN</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1-11-79</b>  |  | 2b. HOUR <b>11:10 AM</b>   |  |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>4 22 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALT. CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESLADY</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>                                |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13e. STREET ADDRESS <b>2ND FL. 3923 CLARKS LA., #21215</b>                                   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM SCHEML</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>KATHY KATIE FEDEROWITZ UNKNOWN</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>081-01-0528</b>   |  | 17. INFORMANT <b>MR. FRED ROSEN</b> ADDRESS <b>654 TWIN BRIDGE DR., RADNOR, PA 19087</b>     |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO Pulmonary ARREST</b>   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 2396 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRAIN TUMOR</b>  |  |  |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>12-13-78</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN TUMOR</b>   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-20</b> , 19 <b>78</b> , to <b>1/11</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>1/11/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Gerard A. Garguilo</b>  |  |  |  | DEGREE <b>MD</b>  |  |  |  | 22c. DATE SIGNED <b>1-11-79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GERARD A. GARGUILO</b>   |  |  |  | 22e. ADDRESS <b>SINAI HOSPITAL</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL/REMOVAL</b>   |  |  |  | 23b. DATE <b>JAN. 15, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT. ARARAT</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>LONG ISLAND NEW YORK</b>            |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>  |  |  |  |   |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215   |  |  |  |   |  |  |  |  |  |   |  |

12310-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01352<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Albert R. Schumachen, Jr.  |  |  |  | January 20, 1979  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 4 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>533 Pontiac Avenue |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-Baltimore  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>City Police   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>-----  |  |  |  |
| 13c. CITY OR TOWN<br>Baltimore   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13e. STREET ADDRESS<br>533 Pontiac Avenue 21225  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Albert R. Schumachen, Sr.   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rachel J. Eichelberger  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>214-40-8604   |  | 17. INFORMANT ADDRESS<br>Mrs. Sheridan L. Williams 21108<br>8242 Mimico South  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCUT D<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1970, 19, to 1/19/79, 1979, that (I) (we) lost saw the deceased alive on 1/19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>[Signature] MD   |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>1/22/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. N. Sosnowski   |  |  |  | 22e. ADDRESS<br>4066 Ritchie Hwy Balto. 21225   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/23/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie Anne Arundel Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Mc Cully Funeral Home of Brooklyn   |  |  |  | 24b. ADDRESS<br>237 E. Patapsca Avenue Balto., Md. 21225  |  | 24c. DATE REC'D. BY REGISTRAR<br>JAN 23 1979   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

100-1325

xxx

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-01353

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EVELYN ELAINE SCHUMAN  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 1 79  |   |  | 2b. HOUR<br>9 <sup>30</sup> P M   |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 25 21  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>KOPPERS CO.  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>648 S. PAYSON STREET, 21223  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GROVER   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINNIE EVANS                          |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                      |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>217-09-0034  |  |   | 17. INFORMANT<br>ADDRESS LINTHICUM, MD.<br>FRANCIS P. SCHAECHER, 307 ARDMORE RD. 21090 |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subendocardial myocardial Infarct</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d):   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-1</u> 19 <u>79</u> to <u>1-1</u> 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>1-1</u> 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>A. Osei-Wusu</u><br>DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>1/2/78  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. OSEI-WUSU  |  |   |  | 22e. ADDRESS<br>St. Agnes Hospital  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>01-05-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.   |  |   |  | 24b. ADDRESS<br>4107 WILKENS AVE.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Crassey</u>  |  |

18-01223



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                         |   |   | 79-01354<br>REG. NO.  |  |
|--|-------------------------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Sophia A Schumann</i>   |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1/17/79</i> |   | 2b. HOUR<br><i>5:05 A.M.</i>                 |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec. 14 1904</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i>  |                         |   | 10. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MD</i>    |   |  |
| 11. CITY OR TOWN OF DEATH<br><i>Baltimore, Md.</i>   |                         | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>North Charles General Hosp</i>        |   | 13. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Sewing Mach. Opr.-Sewing</i>  |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>  |                         | 13b. COUNTY<br><i>Balto.</i>  |   | 13c. CITY OR TOWN<br><i>Balto.</i>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         | 13e. STREET ADDRESS<br><i>907 Bonaparte Ave.</i>  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph O'Donnell</i>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Veronica Kuschinski</i>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>no</i>  |  |
| 16b. SOCIAL SECURITY NO.<br><i>215-07-2226</i>   |                         | 17. INFORMANT<br><i>Veronica Engelbach</i>  |   | 17. ADDRESS<br><i>1012 Bonaparte Ave.</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Hepatic and Renal failure</i><br><i>1519</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Metastatic disease to the liver &amp; ascites</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <i>2 Ca of the stomach &amp; GI bleed</i><br>DUE TO, OR AS A CONSEQUENCE OF |                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |                         |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/7</i> , 19 <i>79</i> , to <i>1/17</i> , 19 <i>79</i> , that (I) (we) lost<br>saw the deceased alive on <i>1/17</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |                         |   |   |   |  |
| 22b. SIGNATURE<br><i>H. Al-Midani</i>  |                         | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>1-17-79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>H. Al-Midani MD</i>  |                         | 22e. ADDRESS<br><i>North Charles General Hosp</i>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |                         | 23b. DATE<br><i>1/19/79</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer</i>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. MD.</i>  |                         | 24. FUNERAL DIRECTOR<br>NAME <i>Schimunek Funeral Home, Inc.</i> ADDRESS <i>3331 Brehms Lane Balto. Md. 21213</i>                                     |   |   |  |
| DATE REC'D. BY REGISTRAR<br><i>JAN 18 1979</i>   |                         | 25b. REGISTRAR'S SIGNATURE<br><i>Patrick McCreedy</i>   |   |   |  |

BP



42010-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 79-01355<br>REG. NO.   |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
|  |  | FIRST MIDDLE LAST<br>Elmer A. Schurman  |  | MONTH DAY YEAR<br>Januray 4, 1979  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 2b. HOUR<br>A.M.   |  |
| 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 15, 1906   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>404 N. Linwood Avenue |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD   |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Manager  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Grocery Wholesale   |  |  |  |
| 13a STATE<br>Md.   |  | 13b COUNTY<br>----  |  | 13c CITY OR TOWN<br>Baltimore  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Carl Schurman   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Helen Fitzberger   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>212-07-8556  |  | 17. INFORMANT ADDRESS<br>404 N. Linwood Ave.-<br>Mrs. Dorothy V. Schurman-Balto., Md.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO-VASC. DISEASE</u><br><u>4292</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ARTERIOSCLEROSIS</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | 21224.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1976, to Jan 4, 1979, that (I) (we) last saw the deceased alive on Jan 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Andrew Lemischka</u>  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANDREW LEMISCHKA MD   |  | 22e. ADDRESS<br>2608 E. BALTIMORE ST., BALTO, MD 21224  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/8/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery   |  |
| 24. FUNERAL DIRECTOR NAME<br>John H. Moran, Inc.   |  | ADDRESS<br>3000 E. Baltimore St.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Hester McCreedy   |  |  |  |

50-01322



RECORDED  
INDEXED  
FBI  
JAN 17 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 79-01356<br>REG. NO.  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  |   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILTON E. SCHURMAN</b>   |  |  |  |   |  | 1 19 79  |  | 7:00A   |  | M   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-15-1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adolph Schurman</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Moberger</b>               |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-14-7073</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Emory Burke - 3702 Raspe Ave. - 21206</b>         |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>DAYS</b>                                  |  |
| 410 - DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>INTERNAL CAPSULE CEREBROVASCULAR ACCIDENT</b>   |  |  |  |   |  |  |  |   |  | 5 WEEKS   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>   |  |  |  |   |  |  |  |   |  | YEARS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>ORGANIC HEART DISEASE -- POSSIBLE RECENT M.I.</b>   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>12/12</b> , 19 <b>78</b> , to <b>1/19</b> , 19 <b>79</b> , that I (we) last saw the deceased alive on <b>1/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John Lavin</b> M.D.  |  |  |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1-19-79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN LAVIN</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1-23-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                      |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kelly</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01357

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Miriam</b> <b>G.</b> <b>Schwartz</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>January</b> Day <b>3</b> Year <b>1979</b>                         |   | 2b. HOUR<br><b>8:45</b> M  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>March 30, 1918</b>   |   | 6. AGE (In years lost birthday)<br><b>60</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pittsburgh</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Pa. U. S. A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Balto.</b>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Westview Park</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1017 Kent Ave.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Sales Lady Hutzler's</b>                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Westview</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>1017 Kent Ave.</b>     |  |
| 14. FATHER'S NAME First Middle Last<br><b>Joseph C. Weigand</b>  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Catherine Hohner</b>                                 |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  | 16b. SOCIAL SECURITY NO.<br><b>167 03 3930</b>  | 17. INFORMANT <b>1017 Kent Ave. Westview Park, Md.</b><br><b>Mr. Wilson J. Schwartz 21228</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic out cell</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b><br><b>13 months</b> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 23, 1977</b> , to <b>Jan 3, 1979</b> , that (I) (we) last saw the deceased alive on <b>Jan 2, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Michael Purtell</b><br><b>Michael Purtell M.D.</b>  | DEGREE  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             | 22c. DATE SIGNED<br><b>Jan 5 1979</b>   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MICHAEL PURTELL</b>   | 22e. ADDRESS<br><b>2827 PAMIE PIENY CT BALT MD 21209</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Jan. 6, 1979</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Sykesville, Md.</b>                         |   |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>  |   | ADDRESS<br><b>5151 Balto. National Pike Balto. Md. 21229</b>  | 25a. REC'D BY REGISTRAR<br><b>JAN 10 1979</b><br>DATE   | 25b. REGISTRAR'S SIGNATURE<br><b>Harry McCreedy</b> |  |

12810-05



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01358

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>WALTER T. SCHWARTZ</b>  |   |   | 2a DATE OF DEATH MONTH <b>JAN</b> DAY <b>4</b> YEAR <b>1979</b> 2b HOUR <b>6:45P.M.</b>              |  |   |
| 3 SEX <b>M</b>  | 4 RACE <b>W</b>   | 5 DATE OF BIRTH MONTH <b>10</b> DAY <b>16</b> YEAR <b>1914</b>  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |  | IF UNDER 1 YEAR IF UNDER 24 HRS.  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |   |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOSPITAL</b> |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GUARD</b>                            |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>CITY</b>   |
| 13a. STATE <b>MD.</b> 13b. COUNTY <b></b> 13c. CITY OR TOWN <b>BALTO.</b>   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS <b>2418 McELDERRY ST.</b>   |
| 14 FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>SCHWARTZ</b> LAST <b></b>  |   |   | 15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b></b> LAST <b></b>                           |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>  |   | 16b. SOCIAL SECURITY NO. <b>W.W. II 214-05-3159</b>   | 17 INFORMANT ADDRESS <b>Mrs. Rosalie A. Schwartz - 2418 Mc Elderry St.</b>                           |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b><br><b>1579</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pancreatic Carcinoma</b><br>(c) <b></b>       |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 3, 1979</b> to <b>Jan. 4, 1979</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 4, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE <b>Muran Lal</b>   |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>1-4-79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. M. Bijpuria</b>  |   | 22e. ADDRESS <b>Church Hospital Corp.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |   | 23b. DATE <b>1-8-79</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>  |  | 23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b></b>  |
| 24. FUNERAL DIRECTOR NAME <b>Charles Miller</b> ADDRESS <b>2334 Jefferson St.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert McElroy</b>                               |   |

MEDICAL CERTIFICATION

78-01328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |   |   |                                    |  |   |   |   | 79-01359  |  |
|--|--|------------------------------|---|---|------------------------------------|--|---|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                              | 2a. DATE OF DEATH   |   |                                    |  |   |   | 2b. HOUR  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              | FIRST   |   |                                    | MIDDLE   |   |   | LAST  |   |  |
| Alice  |  |                              | SCOTT   |   |                                    | January 31 1979  |   |   | 9: A M  |   |  |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | 7. IF UNDER 1 YEAR  |   |  |
| FEMALE   |  | NEGROID                      |   | 2-8-1895  |                                    |  | 83  |   | MONTHS DAYS HOURS MIN   |   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |   |   |  |
| VA   |  | U.S.A.                       |   |   |                                    |  | Baltimore City MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |
| Baltimore  |  |                              | Maryland General Hospital   |   |                                    |  |   |   |   |   |  |
| 13a. STATE   |  |                              | 13b. COUNTY   |   |                                    | 13c. CITY OR TOWN  |   |   | 13d. INSIDE CITY LIMITS?  |   |  |
| Md.  |  |                              | BALTO.  |   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   |   | 13e. STREET ADDRESS   |   |  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME  |   |                                    |  |   |   |   |   |  |
| John Bee   |  |                              | Lizza GANTH   |   |                                    |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.  |   |                                    | 17. INFORMANT  |   |   | ADDRESS   |   |  |
| NO   |  |                              |   |   |                                    | Zeb Bee  |   |   | 1353 CALHOUN ST.  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Status Postoperative Colonic Carcinoma</u><br>(c) <u>Arteriosclerotic Cardiovascular Disease</u> |  |                              |   |   |                                    |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |   |   |                                    |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                    |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |  |
| 1-18-79  |  |                              | Sigmoid Colon Carcinoma And Cholelithiasis  |   |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>January 1</u> , 19 <u>79</u> , to <u>January 31</u> , 19 <u>79</u> , that (we) lost<br>saw the deceased alive on <u>January 31</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (not) view the body after death.       |  |                              |   |   |                                    |  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>John Johnson</u><br>DEGREE<br>M.D.  |  |                              |   |   |                                    | 22c. DATE SIGNED<br>2-1-79   |   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Johnson, M.D.  |  |                              |   |   |                                    | 22e. ADDRESS<br>c/o Maryland General Hospital                                  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                              | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |   |  |
| Burial   |  |                              | 2/5/78  |   | WESTVIEW MEM.                      |  |   | BALTO. Md.                                  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>V.R. Bailey F.H.   |  |                              |   |   |                                    | ADDRESS<br>1348 CALHOUN ST.  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1979 |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. Bailey</u> |  |

50-01320

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |   |  | 79-01360<br>REG. NO.  |  |  |  |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edna Scott</b>   |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 3 19 79</b> |  | 2b. HOUR<br>M<br><b>5:55 PM</b>              |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 9 49</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>29 YRS.</b>                    |  | IF UNDER 24 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 3 19 79</b>  |  | 2d. HOUR<br>M<br><b>5:55 PM</b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2508 Francis Street</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Scott</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Treva Holmes</b> |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |                         |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT ADDRESS<br><b>William Scott 2508 Francis Street</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b><br><b>4254</b><br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                         |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |                         |  |   |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                         |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |  |  |  | DATE SIGNED <b>1/4/79</b>   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>1/8/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 East North Ave.</b>   |  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony MacCreedy</b>               |  |   |  |   |  |  |  |

50-01360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |                         | 79-01361<br>REG. NO.                                  |  |
|---|--|---|--|---|--|---|--|--|-------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elizabeth Scott</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 24, 1979</b>                                  |  |  | 2b. HOUR<br><b>6 AM</b> |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 24, 1932</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |                         |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  |  | MD.                     |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Statistician</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Invest. Concl</b>  |                         |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1328 Weldon Avenue</b>   |                         |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert LeVert</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Elizabeth Snovell</b>  |  |   |  |  |                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 28 9039</b>   |  | 17. INFORMANT<br><b>Kenneth B. Scott</b>  |  | ADDRESS<br><b>Same</b>  |  |  |                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b><br><b>4 mos</b> |  |   |  |   |  |   |  |  |                         |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>DIABETES MELLITUS, JUVENILE</b>   |  |   |  |   |  |   |  |  |                         |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                         |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                         |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                         |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1979, to 1979, that (I) (we) last saw the deceased alive on 1/16/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |                         |   |  |
| 22b. SIGNATURE<br><b>George N. Agapitos</b>   |  |   |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>1/25/79</b>   |                         |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. George N. Agapitos</b>  |  |   |  | 22e. ADDRESS<br><b>Maryland General Hospital</b>  |  |   |  |  |                         |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>27 Jan. 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Towson, Balto. Co. Maryland</b>                |  |  |                         |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgess Funeral Home</b>   |  |   |  | ADDRESS<br><b>3631 Falls Road 21211</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1979</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Boring</i> |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10-22a Film 6528 2/28/79 r528  
 FOR  
 1- STATE  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01362

|  |  |   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
|--|--|---|--|---|--|--|--|--|--|------------------|--|--------------------------------------|--|-------|--|--------------------------|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH                      |  | ESTIMATED        |  | MONTH                                |  | DAY   |  | YEAR                     |  | 2b. HOUR   |  |
| James  |  | B   |  | Scott   |  |  |  | 2a. DATE KNOWN OF DEATH                      |  | ESTIMATED        |  | MONTH                                |  | DAY   |  | YEAR                     |  | 2b. HOUR   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                               |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY                      |  | YEAR       |  |
| male   |  | black   |  | Unkn.   |  | 72   |  | MONTHS                                       |  | DAYS             |  | HOURS                                |  | MIN.  |  | 7c. DATE PRONOUNCED DEAD |  | 1 30 19 79 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED  |  | WIDOWED                                      |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |                          |  |            |  |
| Unkn.  |  | Unkn.   |  | Unkn.   |  | Unkn.  |  | Unkn.  |  | Unkn.            |  | Baltimore City                       |  |       |  |                          |  |            |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Baltimore  |  | 1535 Leslie Street  |  | Unkn.   |  | Unkn.  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS                          |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Md.  |  | ---   |  | Balto.  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 1535 Leslie St.                              |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 14. FATHER'S NAME  |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME                                 |  | MIDDLE                                       |  | LAST             |  |                                      |  |       |  |                          |  |            |  |
| Unkn.  |  |   |  |   |  | Unkn.  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Unkn.  |  | Unkn.   |  | Unkn.   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I DEATH WAS CAUSED BY:                                 |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 4292   |  |   |  | Arteriosclerotic cardiovascular disease                                       |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF                           |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
|  |  |   |  | (c)   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
|  |  |   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
|  |  | P.M. 19   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
|  |  |   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Ann M. Dixon, M.D.   |  | Assistant   |  | 1/30/79   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Ann M. Dixon, M.D.   |  | 111 Penn Street, Balto, MD 21201                            |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Removal  |  | 2/6/79  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                               |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |
| Anatomy Board  |  | Balto., Md.   |  | FEB 7 1979  |  | [Signature]  |  |  |  |                  |  |                                      |  |       |  |                          |  |            |  |

18-01385

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01363

1- FOR  
STATE  
REGISTRAR

|  |         |  |        |  |                         |   |                  |                                   |                          |   |  |
|--|---------|--|--------|--|-------------------------|---|------------------|-----------------------------------|--------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE | LAST   | 2a. DATE KNOWN OF DEATH |   | 2b. MONTH        | 2c. DAY                           | 2d. YEAR                 | 2e. HOUR  |  |
| WALTER D. SCOTT, III   |         |  |        |  | 1 21 1979               |   |                  |                                   |                          |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS)  | IF UNDER 1 YR.          |   | IF UNDER 24 HRS. |                                   | 7c. DATE PRONOUNCED DEAD |   |  |
| male   | white   | July 3, 1952   |        | 26 YRS.  |                         |   |                  |                                   | 1 21 1979                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                  |                                   |                          |   |  |
| Maryland   |         | U. S. A.   |        |  |                         | Baltimore City MD.  |                  |                                   |                          |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                  | 12b. KIND OF BUSINESS OR INDUSTRY |                          |   |  |
| Baltimore  |         | South Baltimore General Hosp.  |        |  |                         | Salesman  |                  | New Cars                          |                          |   |  |
| 13a. STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                         | 13d. INSIDE CITY LIMITS?  |                  | 13e. STREET ADDRESS               |                          |   |  |
| Maryland   |         | Baltimore  |        | Lutherville  |                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                  | 215 Welford Road                  |                          |   |  |
| 14. FATHER'S NAME  |         |  |        | 15. MOTHER'S MAIDEN NAME   |                         |   |                  |                                   |                          |   |  |
| Walter D. Scott, Jr.   |         |  |        | Catherine Leonard  |                         |   |                  |                                   |                          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  |        | 16b. SOCIAL SECURITY NO.   |                         | 17. INFORMANT ADDRESS   |                  |                                   |                          |   |  |
| NO   |         |  |        | 219-58-3207  |                         | Walter D. Scott, Jr. Same As #13e   |                  |                                   |                          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries</u><br>8/20<br>Conditions, if any, which gave rise to immediate cause (c) stating the <u>underlying cause last</u> .<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                         |   |                  |                                   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |  |        |  |                         |   |                  |                                   |                          |   |  |
| 19a. DATE OF OPERATION   |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                         |   |                  |                                   |                          | 20. AUTOPSY?  |  |
|  |         |  |        |  |                         |   |                  |                                   |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:04 AM 1-20- 1979  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                  |                                   |                          |   |  |
|  |         |  |        |  |                         | Driver in auto-tractor trailer collision.                                     |                  |                                   |                          |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |  |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>bridge  |                         | 21f. LOCATION<br>STREET<br>Francis Scott Key Bridge                           |                  | CITY OR TOWN<br>Anne Arundel      |                          | STATE<br>Md.  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |        |  |                         |   |                  |                                   |                          |   |  |
| ACTUAL SIGNATURE   |         |  |        | TITLE (SPECIFY)<br>M.D. Assistant  |                         |   |                  | DATE SIGNED 1-21-79               |                          |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |        | ADDRESS  |                         |   |                  |                                   |                          |   |  |
| Ann M. Dixon, M.D.   |         |  |        | 111 Penn St.   |                         |   |                  |                                   |                          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |        | 23b. DATE  |                         | 23c. NAME OF CEMETERY OR CREMATORY  |                  | 23d. LOCATION<br>CITY OR TOWN     |                          |   |  |
| Burial   |         |  |        | 1-24-79  |                         | Dulaney Valley Memorial   |                  | Cockeysville, Balto. Md.          |                          |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         |  |        |  |                         | 25a. DATE REC'D. BY REGISTRAR   |                  | 25b. REGISTRAR'S SIGNATURE        |                          |   |  |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |         |  |        |  |                         | JAN 23 1979   |                  | [Signature]                       |                          |   |  |

58-01383



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01364

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |                                  |  |                    |  |          |  |
|---|--|---|--|---|--|---|--|----------------------------------|--|--------------------|--|----------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  |                    |  | 2b. HOUR |  |
| Franklin  |  | W.  |  | Seitz   |  |   |  | Jan. 7, 1979                     |  |                    |  | M        |  |
| 3 SEX   |  | 4. RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR                  |  | IF UNDER 24 HRS    |  |          |  |
| Male  |  | White   |  | 9 12 1884   |  | 94  |  | MONTHS DAYS                      |  | HOURS MIN.         |  |          |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                  |  |                    |  |          |  |
| Penna.  |  | USA   |  |   |  | Baltimore   |  |                                  |  |                    |  | MD.      |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                  |  |                    |  |          |  |
| Baltimore   |  | 814 W. 36th St.   |  | Funeral Dir.  |  | Self-Emp.   |  |                                  |  |                    |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13a STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?          |  | 13e STREET ADDRESS |  |          |  |
| Md.   |  |   |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 814 W. 36th St.                  |  |                    |  |          |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                  |  |                    |  |          |  |
| PenField  |  | Seitz   |  | Catherine   |  | Fisher  |  |                                  |  |                    |  |          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                     |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT  |  | ADDRESS   |  |                                  |  |                    |  |          |  |
| No  |  | --  |  | 217-26-4423   |  | Austin A. Seitz   |  | 3925 Beech Ave.                  |  |                    |  |          |  |

|  |  |   |  |
|--|--|---|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>heart failure</u>   |  | 6 months  |  |
| 4290 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (b) <u>Chronic myocarditis</u>   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |
| (c)  |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> 19 <u>65</u> to <u>11/7</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Reuben Hoffman</u>                                |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>1/8/79</u>                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>REUBEN HOFFMAN</u>  |  | 22e. ADDRESS<br><u>846 W. 36th St., Baltimore, Md.</u>                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |

|  |  |           |  |                                    |  |  |  |
|--|--|-----------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 1/10/79   |  | Druid Ridge Cem.                   |  | Baltimore, Md.                             |  |

|  |  |                                    |  |   |  |  |  |
|--|--|------------------------------------|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><u>A. Alan Seitz, Funeral Home</u> |  | ADDRESS<br><u>3818 Roland Ave.</u> |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 10 1979</u> |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |
|--|--|------------------------------------|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-01304



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-01365<br>REG. NO.  |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>MOULIE CAROLINE SELBY</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 21 1979</b>                          |   | 2b. HOUR <b>10:25P</b>   |
| 3. SEX <b>female</b>   | 4. RACE <b>white</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 26, 1923</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.                                   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHN HOKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b> | 12b. KIND OF BUSINESS OR INDUSTRY <b>Athome</b>                                   |  |
| 13a. STATE <b>Maryland</b>   |  |  | 13b. COUNTY <b>Carroll</b>   | 13c. CITY OR TOWN <b>New Windsor</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>M. Jesse Selby</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rae Wagner</b>                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>unknown</b>  | 17. INFORMANT ADDRESS <b>Mrs. Virginia Little, Westminster, Md.</b>              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b>   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17mo 2yrs</b>  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Breast Ca</b>   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hyper Calcemia</b>   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hyper Calcemia</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>1/2/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma</b>  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1977</b> , to <b>Jan 22, 1979</b> , that (I) (we) lost saw the deceased alive on <b>1/21/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |  |  |   |  |
| 22b. SIGNATURE <b>Paul D Scanlon</b> DEGREE  |  |  |  | 22c. DATE SIGNED <b>1/22/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Scanlon</b>   |  |  |  | 22e. ADDRESS <b>Johns Hopkins Hospital Dept Medicine</b>                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/24/1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Winters Cemetery</b>                       |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>New Windsor, Md.</b>  |
| 24. FUNERAL DIRECTOR NAME <b>D. W. Hartzler</b>  |  | ADDRESS <b>New Windsor, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1979</b>                                  | 25b. REGISTRAR'S SIGNATURE <b>Robert K. Hartzler</b>   |

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TO HOSPITAL: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician retained by the hospital or attending physician.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01366  
REG. NO.

|  |  |   |   |  |                             |  |  |
|--|--|---|---|--|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL JOSEPH SERIO</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 7, 1979</b> |  | 2b. HOUR<br><b>7:45A.M.</b> |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 30 23</b>   |                             | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>KRUG MACHINE</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>ARBUTUS</b>  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH SERIO</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE UNKNOWN</b>  |   | 13a. STREET ADDRESS<br><b>4723 BENSON AVENUE</b>   |                             | CO.  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>   |  | 16b. SOCIAL SECURITY NO<br><b>216-12-6681</b>   |   | 17 INFORMANT<br><b>MARIE T. SERIO,</b>   |                             | ADDRESS<br><b>4603 BENSON AVENUE</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA LUNG WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |                             |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <b>1/6/79</b> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                             |  |  |
| 22b. SIGNATURE<br><b>J. H. JOSEPH MD</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |                             | 22c. DATE SIGNED<br><b>1/6/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. H. JOSEPH MD</b>  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |   |  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>01-10-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTIMORE MD.</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1979</b>   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>  |  |

BP \_\_\_\_\_

78-01388